ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1056

central registry; background checks

Purpose

Requires the Department of Economic Security (DES) to conduct Central Registry checks for additional people who provide direct services to children or vulnerable adults.

Background

A report of child abuse or neglect is substantiated when Child Protective Services (CPS) or the juvenile court finds probable cause to believe the abuse or neglect occurred and after the alleged perpetrator has been afforded the person's due process rights. The Central Registry is a confidential database maintained by DES of substantiated reports of child abuse and neglect, including information on the perpetrator, child victim, the abuse or neglect that occurred and the date the report was received.

Statute limits the use of the Central Registry to several specified purposes. In addition to other statutory uses, DES must use the Central Registry as one factor in determining the qualifications of persons who are applying: 1) to become licensed, certified or registered child caregivers; 2) for positions that provide direct service to children or vulnerable adults; and 3) for contracts, including employees of the potential contractor, for positions that provide direct service to children or vulnerable adults. According to DES, currently new employees of contractors that provide services to children or vulnerable adults are checked against the Central Registry during the contractor's annual Central Registry update. S.B. 1056 requires a Central Registry check upon hiring, and also specifies that subcontractors and their employees must be checked.

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

1. Requires DES to use Central Registry information to conduct background checks as one factor to determine qualifications for:
   a) home and community based services certification for vulnerable adults;
   b) persons who are employed in positions that provide direct service to children or vulnerable adults;
   c) employees and prospective employees of a contractor for positions that provide direct service to children or vulnerable adults; and
   d) a subcontractor of a contractor and the subcontractor's employees and prospective employees for positions that provide direct service to children or vulnerable adults.
2. Specifies that only Central Registry information may be used to conduct background checks pursuant to statute.
3. Makes technical and conforming changes
4. Becomes effective on the general effective date

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1094

mandated health coverage; report

Purpose

Requires a legislative committee of reference (COR), when considering a proposal to mandate health insurance coverage of a particular treatment or service, to examine data from multiple sources and evaluate the effectiveness of the proposed treatment or service.

Background

There are numerous types of organizations that offer various types of health insurance coverage. Examples of health insurers include disability, group disability and blanket disability insurers, health care services organizations and hospital, medical, dental or optometric service corporations. The structure of the insurance issued by these organizations, including the scope, duration and choice of benefits offered, varies.

Statute contains requirements for health insurance, including mandates to cover specific services or supplies. Not every mandate applies to every type of insurer, and the requirements vary for each type of insurer. The Arizona Department of Insurance (DOI) maintains a list on its website of the health insurance benefits that are mandated by Arizona law (www.id.state.az.us/publications/MANDATES_2009.pdf).

Pursuant to A.R.S. § 20-181, an organization or individual advocating a legislative proposal that would mandate health coverage or the offering of health coverage of a treatment or service must submit a written report to the Joint Legislative Audit Committee (JLAC). Statute requires the report to address, at a minimum, specific factors pertaining to the proposal's social and financial impact (A.R.S. § 20-182).

JLAC is required to assign the written report to the appropriate legislative COR. The COR must hold at least one hearing and take public testimony after receiving the report. The COR is required to study the written report and deliver a report of its recommendations to JLAC, the Speaker of the House of Representatives, the President of the Senate, the Governor and the Director of the Department of Insurance by December 1 of the year in which the report is submitted (A.R.S. § 20-183).

There is no anticipated fiscal impact to the General Fund associated with this legislation.

Provisions

1. Requires a legislative COR, after evaluating statutorily prescribed social and financial impact factors of a health insurance mandate proposal, to examine data from multiple sources and evaluate the effectiveness of the proposed treatment or service.
2. Becomes effective on the general effective date.

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011
SENATE BILL 1094

AN ACT

AMENDING SECTION 20-183, ARIZONA REVISED STATUTES; RELATING TO MANDATED HEALTH COVERAGE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 20-183, Arizona Revised Statutes, is amended to read:

START_STATUTE20-183. Report procedures and deadlines
A person or a legislator advocating a legislative proposal pursuant to section 20-181 shall submit a written report explaining the factors prescribed in section 20-182 to the joint legislative audit committee established by section 41-1279. The report must be submitted on or before September 1 before the start of the legislative session for which the legislation is proposed. The joint legislative audit committee shall assign the written report to the appropriate legislative committee of reference established pursuant to section 41-2954. The legislative committee of reference shall hold at least one hearing and take public testimony after receiving the report. AFTER EVALUATING THE FACTORS PRESCRIBED IN SECTION 20-182, THE LEGISLATIVE COMMITTEE OF REFERENCE SHALL EXAMINE DATA FROM MULTIPLE SOURCES AND EVALUATE THE EFFECTIVENESS OF THE TREATMENT OR SERVICE PROPOSED. The legislative committee of reference shall study the written report and deliver a report of its recommendations to the joint legislative audit committee, the speaker of the house of representatives, the president of the senate, the governor and the director of the department of insurance on or before December 1 of the year in which the report is submitted.
END_STATUTE

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1113

ALTCS; care facilities; standards

Purpose

Prohibits existing licensed facilities operated by the state or contracted with the Department of Economic Security (DES) to provide intermediate care facilities for mental retardation services for developmental disability members.

Background

ALTCS is Arizona's Medicaid long-term care program and is administered by the Arizona Health Care Cost Containment System Administration. For elderly and physically disabled ALTCS members, the program provides acute care services, behavioral health services, institutional services, home and community based services and case management services. ALTCS delivers services in a managed care system through contracted prepaid, capitated arrangements with a network of program contractors.

The fiscal impact related to this legislation is unknown.

Provisions

1. Prohibits existing licensed facilities operated by the state or contracted with the DES to provide intermediate care facility for mental retardation services for a member who has a developmental disability.
2. Provides technical and conforming changes.
3. Becomes effective on general effective date.

Fiftieth Legislature, First Regular Session
Appropriations
S.B. 1113

PROPOSED AMENDMENT
SENATE AMENDMENTS TO S.B. 1113
(Reference to printed bill)

Page 1, line 31, after "settings" striker remainder of line
Strike line 32, insert "or existing licensed facilities operated by this state or under contract with the department."
Amend title to conform

Page 1, line 30, strike "~~,~~ OR" insert ","
Line 32, after "~~1988~~" insert "AND PRIVATE FACILITIES THAT CONTRACT WITH THE DEPARTMENT"
Amend title to conform

ANDY BIGGS

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1189

developmentally disabled; residential setting

Purpose

Requires the Department of Economic Security (DES) to transfer certain developmentally disabled individuals to intermediate care facilities for the mentally retarded, from January 1 to July 1, 2012.

Background

According to DES, the Division of Developmental Disabilities (DDD) provides services and programs to 30,667 people with developmental disabilities as of June 30, 2010. To be eligible for DDD services, a person must have a chronic disability that is manifested before the age of 18 and is attributable to a cognitive disability, cerebral palsy, epilepsy or autism. The person also must have substantial limitations in specified life functions. Individuals with developmental disabilities who qualify for services through DDD may also be eligible for services through the Arizona Long Term Care System (ALTCS), which provides long term and acute care services to individuals with developmental disabilities who are at risk of institutionalization and who meet financial eligibility criteria.

DDD provides services in a variety of living environments. According to DES, as of June 30, 2010, a total of 201 clients lived in institutional settings, which consist of nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs). A *nursing facility* is a Medicaid certified facility that provides inpatient room, board and nursing services to individuals who need them on a continuous basis but do not require hospital care or direct daily care from a physician. An *ICF/MR* is a facility whose primary purpose is to provide health, habilitative, and rehabilitative services to people who require them on a continuous basis.

According to the Joint Legislative Budget Committee (JLBC), the budget includes $16,604,700 and 77.7 FTE Positions for Institutional Services in FY 2011. These amounts consist of approximately $4.2 million from the General Fund and $12.4 million from the Long Term Care System Fund. Those amounts consist of an increase for anticipated caseload growth, and is estimated to serve 249 clients. The fiscal impact associated with this legislation is unknown at this time.

Provisions

1. Requires DES, by January 1, 2012, to begin to transfer developmentally disabled individuals who meet the following requirements to ICF/MRs:
   a) individuals who are living in skilled nursing facilities; and
   b) as a result of their developmental disability are, or should be, receiving specialized services in accordance with their preadmission screening and resident review document.
2. Requires DES to complete the transfer by July 1, 2012.
3. Becomes effective on the general effective date.

REFERENCE TITLE: developmentally disabled; residential setting

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1189

Introduced by: Senators Gray: Barto, Klein, Murphy

AN ACT

PRESCRIBING THE RESIDENTIAL SETTING OF CERTAIN DEVELOPMENTALLY DISABLED INDIVIDUALS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Developmentally disabled persons in skilled nursing facilities; transfer to intermediate care facilities
A. On or before January 1, 2012, the department of economic security shall begin to transfer to intermediate care facilities for the mentally retarded all developmentally disabled individuals who are living in skilled nursing facilities and who, as a result of their developmental disability, are, or should be, receiving specialized services in accordance with their preadmission screening and resident review document.
B. The department shall complete the transfer prescribed in subsection A on or before July 1, 2012.

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1216

AHCCCS; obstetric services; copayment

Purpose

Requires a woman to pay a copayment for obstetric services received while enrolled as a member of the Arizona Health Care Cost Containment System (AHCCCS) Administration. Requires the AHCCCS Administration to base copayments on a sliding fee schedule and to establish minimum and maximum copayment amounts.

Background

Under traditional Medicaid, states may require certain beneficiaries to share in the cost of Medicaid services, although there are limits on the amounts that states can impose, the beneficiary groups that may be required to pay and the types of services for which cost-sharing can be charged.

A copayment is a specified dollar amount for each item or service delivered. Currently, some AHCCCS beneficiaries are asked to pay copayments for certain medical services. Beginning October 1, 2010 AHCCCS expanded copayment requirements, outlined in Arizona Administrative Code R9-22-711. According to the AHCCCS Administration certain populations are always exempt from copayments, including:

- children under age 19;
- the seriously mentally ill, as determined by the Arizona Department of Health Services;
- individuals up to age 20 who receive services from the Children's Rehabilitative Services program;
- people in nursing homes and residential facilities; and
- people in hospice care.

In addition, copayments are never charged for:

- hospitalization;
- emergency services;
- family planning services and supplies;
- pregnancy related health care; and
- services paid on a fee-for-service basis.

The traditional Medicaid population includes pregnant women up to 150% FPL.

The fiscal impact of the legislation is unknown at this time.

Provisions

1. Requires a woman who is enrolled in AHCCCS and receives obstetric services to pay a copayment for the obstetric services.
2. Requires the Director of AHCCCS to adopt rules that specify a sliding fee schedule for obstetric service copayments.
3. Requires the rules to establish minimum and maximum copayment amounts for the obstetric services, as follows:
   a) a minimum copayment of $150; and
   b) a maximum copayment of $1,000.
4. Specifies that minimum and maximum copayments apply to a doctor and to a hospital.
5. Becomes effective on the general effective date.

Fiftieth Legislature, First Regular Session
Appropriations
S.B. 1216

PROPOSED AMENDMENT
SENATE AMENDMENTS TO S.B. 1216
(Reference to printed bill)

Page 4, after line 41, insert:
"P. THE SPONSORS AND COSPONSORS OF THIS LEGISLATION SHALL MEET WITH AT LEAST FIVE WOMEN THAT WILL BE AFFECTED BY THIS LEGISLATION TO EDUCATE THEM AS TO THE REASON FOR THE LEGISLATION."
Amend title to conform

PAULA ABOUD

REFERENCE TITLE: AHCCCS; obstetric services; copayment

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1216

Introduced by: Senator Allen: Representatives Barton, Crandell

AN ACT

AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 36-2907, Arizona Revised Statutes, is amended to read:
START_STATUTE36-2907. Covered health and medical services; modifications; related delivery of service requirements; definition

A. Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:

1. **Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.]**
2. **Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.**
3. **Other laboratory and x-ray services ordered by a physician or a primary care practitioner.**
4. **Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1, 2006,~~ Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.**
5. **Medical supplies, durable medical equipment and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.**
6. **For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.**
7. **Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.**

8. **Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.**
9. **Podiatry services ordered by a primary care physician or primary care practitioner.**
10. **Nonexperimental transplants approved for title XIX reimbursement.**
11. **Ambulance and nonambulance transportation, except as provided in subsection G of this section.**

B. **The limitations and exclusions for health and medical services provided under this section are as follows:**
   1. ~~**Beginning on October 1, 2002,**~~ **Circumcision of newborn males is not a covered health and medical service.**
   2. **For eligible persons who are at least twenty-one years of age:**
      a) **Outpatient health services do not include occupational therapy or speech therapy.**
      b) **Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand ~~five hundred~~ FIVE HUNDRED dollars per contract year.**
      c) **Insulin pumps, percussive vests and orthotics are not covered health and medical services.**
      d) **Durable medical equipment is limited to items covered by medicare.**
      e) **Podiatry services do not include services performed by a podiatrist.**
      f) **Nonexperimental transplants do not include the following:**
         i. **Pancreas only transplants.**
         ii. **Pancreas after kidney transplants.**
         iii. **Lung transplants.**
         iv. **Hemopoetic cell allogenic unrelated transplants.**
         v. **Heart transplants for non-ischemic cardiomyopathy.**
         vi. **Liver transplants for diagnosis of hepatitis C.**
      g) **Beginning October 1, 2011, bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.**
      h) **Well exams are not a covered health and medical service, except mammograms, pap smears and colonoscopies.**

C. **The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.**

D. **The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.**

E. **The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.**

F. **The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.**

G. **The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided to persons who are eligible pursuant to sections 36-2901.01 and 36-2901.04 and who reside in a county with a population of more than five hundred thousand persons. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.**

H. **The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.**

I. **If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.**

J. **Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).**

K. **All health and medical services provided under this article shall be provided in the geographic service area of the member, except:**
   1. **Emergency services and specialty services provided pursuant to section 36-2908.**
   2. **That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.**

L. **Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes**

including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

M. **The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.**

N. **A WOMAN WHO RECEIVES OBSTETRIC SERVICES PURSUANT TO THIS CHAPTER SHALL PAY A COPAYMENT AS PRESCRIBED BY THE DIRECTOR. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE A SLIDING FEE SCHEDULE BASED ON INCOME FOR THE OBSTETRIC SERVICES COPAYMENT. THE RULES SHALL REQUIRE A MINIMUM COPAYMENT OF ONE HUNDRED FIFTY DOLLARS TO A DOCTOR AND TO A HOSPITAL AND A MAXIMUM COPAYMENT OF ONE THOUSAND DOLLARS TO A DOCTOR AND TO A HOSPITAL.**

O. ~~N.~~ **For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201.**

ARIZONA STATE SENATE
RESEARCH STAFF

AMBER O'DELL
LEGISLATIVE RESEARCH ANALYST
PUBLIC SAFETY &
HUMAN SERVICES COMMITTEE
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TO: MEMBERS OF THE SENATE
PUBLIC SAFETY & HUMAN SERVICES COMMITTEE
DATE: February 15, 2011
SUBJECT: Strike everything amendment to S.B. 1190, relating to developmental disabilities; residential placement

Purpose

Requires the Department of Economic Security (DES) to hold meetings with parents and guardians of developmentally disabled individuals living in certain institutional settings to present placement options.

Background

According to DES, the Division of Developmental Disabilities (DDD) provides services and programs to 30,667 people with developmental disabilities as of June 30, 2010. To be eligible for DDD services, a person must have a chronic disability that is manifested before the age of 18 and is attributable to a cognitive disability, cerebral palsy, epilepsy or autism. The person also must have substantial limitations in specified life functions. Individuals with developmental disabilities who qualify for services through DDD may also be eligible for services through the Arizona Long Term Care System (ALTCS), which provides long term and acute care services to individuals with developmental disabilities who are at risk of institutionalization and who meet financial eligibility criteria.

DDD provides services in a variety of living environments. According to DES, as of June 30, 2010, a total of 201 clients lived in institutional settings, which consist of nursing facilities and

intermediate care facilities for the mentally retarded (ICF/MRs). A *nursing facility* is a Medicaid certified facility that provides inpatient room, board and nursing services to individuals who need them on a continuous basis but do not require hospital care or direct daily care from a physician. An *ICF/MR* is a facility whose primary purpose is to provide health, habilitative, and rehabilitative services to people who require them on a continuous basis. There are five ICF/MRs in Phoenix, four of which are operated by DDD. Approximately 30 people currently reside in those four facilities.

According to the Joint Legislative Budget Committee (JLBC), the budget includes $16,604,700 and 77.7 FTE Positions for Institutional Services in FY 2011. These amounts consist of approximately $4.2 million from the General Fund and $12.4 million from the Long Term Care System Fund. Those amounts consist of an increase for anticipated caseload growth, and is estimated to serve 249 clients. There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

1. Requires DES to conduct meetings with the parents and guardians of individuals with cognitive or developmental disabilities who are served by state ICF/MRs, skilled nursing facilities or intermediate care facilities to present options regarding available placement settings, including, in the case of individuals with cognitive disabilities, placement at privately run facilities.
2. Requires DES to emphasize that the goal of the meetings is informed parental or guardian choice regarding factors such as quality of care, cost, efficiency and active treatment.
3. Requires DES to inform parents and guardians of individuals who are served by state ICF/MRs that closure of the facilities is a possibility in the future and requires DES to ask the parents and guardians for their input on possible closure.
4. Requires DES to complete the meetings by November 15, 2011.
5. Requires DES to submit, by December 1, 2011, a written report to the Governor, the Speaker of the House of Representatives, the President of the Senate and the Secretary of State regarding the meetings, including recommendations relating to the closure of that state ICFMRs.
6. Becomes effective on the general effective date.

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1190

developmental disabilities; intermediate care facilities

Purpose

Requires the Department of Economic Security (DES) to close the four state-operated intermediate care facilities for the mentally retarded (ICF/MRs) in Phoenix and transfer the clients residing in those ICF/MRs to group homes and private, nonprofit ICF/MRs.

Background

According to DES, the Division of Developmental Disabilities (DDD) provides services and programs to 30,667 people with developmental disabilities as of June 30, 2010. To be eligible for DDD services, a person must have a chronic disability that is manifested before the age of 18 and is attributable to a cognitive disability, cerebral palsy, epilepsy or autism. The person also must have substantial

limitations in specified life functions. Individuals with developmental disabilities who qualify for services through DDD may also be eligible for services through the Arizona Long Term Care System (ALTCS), which provides long term and acute care services to individuals with developmental disabilities who are at risk of institutionalization and who meet financial eligibility criteria.

DDD provides services in a variety of living environments. A *group home* is a community residential setting for up to six people that provides supervision, habilitation, and room and board. According to the Joint Legislative Budget Committee (JLBC), approximately 2,200 people live in group homes in FY 2011. Clients with more severe developmental disabilities may require institutional living environments. According to DES, as of June 30, 2010, a total of 201 clients lived in institutional settings, which consist of nursing facilities and ICF/MRs. An *ICF/MR* is a facility whose primary purpose is to provide health, habilitative, and rehabilitative services to people who require them on a continuous basis. There are five ICF/MRs in Phoenix, four of which are operated by DDD. Approximately 30 people currently reside in those four facilities.

The fiscal impact associated with this legislation is unknown at this time.

Provisions

1. Requires DES and its Director (Director) to transfer persons with developmental disabilities who reside in one of the four Phoenix-based ICF/MRs operated by the state into existing group home vacancies and private, nonprofit ICF/MRs in Arizona.
2. Requires DES to do the following:
   a) close the four state-operated ICF/MRs in Phoenix within three months after the general effective date; and
   b) sell the facilities and deposit the proceeds in the state General Fund, after all clients have been transferred.
3. Requires the Director, within 30 days after the general effective date, to prepare an action plan for the closure.
4. Requires the Director to provide a copy of the action plan to the Governor, the President of the Senate (President), the Speaker of the House of Representatives (Speaker), the Chairpersons of the Appropriations Committees (Chairpersons) and the Director of JLBC.
5. Requires the action plan to identify:
   a) all the tasks to be completed,
   b) the title of the person responsible for each task and
   c) the required task completion date.
6. Requires the Director, in making placement decisions, to request and use input from the clients' parents, family members and guardians.
7. Requires DES to do the following when transferring clients to other facilities:
   a) base transfer decisions on the wishes of the clients' parents or guardians; and
   b) make all reasonable efforts to protect the clients' health and safety during the transition process.
8. Requires the Director, no later than nine months after the facilities are closed and all clients have been transferred, to submit a written report relating to the financial and programmatic success of the facilities' closure to the Governor, President, Speaker, Chairpersons and Director of JLBC.
9. Makes technical changes.
10. Becomes effective on the general effective date.

Fiftieth Legislature, First Regular Session
Public Safety and Human Services
S.B. 1190

PROPOSED AMENDMENT
SENATE AMENDMENTS TO S.B. 1190
(Reference to printed bill)

Strike everything after the enacting clause and insert:
"Section 1. Placement of individuals with cognitive or developmental disabilities; meetings; report

A. **The department of economic security shall conduct meetings with the parents and guardians of individuals with cognitive or developmental disabilities who are served by state intermediate care facilities for the mentally retarded, skilled nursing facilities or intermediate care facilities to present options regarding available placement settings, including, in the case of individuals with cognitive disabilities, placement at privately run facilities. The department shall emphasize that the goal of these meetings is informed parental or guardian choice regarding factors such as quality of care, cost and efficiency and active treatment. For individuals who are served by state intermediate care facilities for the mentally retarded, the department shall inform the parents and guardians that closure of these facilities is a possibility in the future and shall ask parents and guardians for their input on possible closure. The department shall complete these meetings on or before November 15, 2011.**

B. **B. On or before December 1, 2011, the department shall submit a written report to the governor, the speaker of the house of representatives and the president of the senate regarding meetings held pursuant to subsection A, including recommendations relating to the closure of the state intermediate care facilities for the mentally retarded. The department shall provide the secretary of state with a copy of this report."**

Amend title to conform

LINDA GRAY

COMMITTEE ON PUBLIC SAFETY AND HUMAN SERVICES

Strike everything after the enacting clause and insert:
"Section 1. Placement of individuals with cognitive or developmental disabilities; meetings; report

A. **The department of economic security shall conduct meetings with the parents and guardians of individuals with cognitive or developmental disabilities who are served by state intermediate care facilities for the mentally retarded, skilled nursing facilities or intermediate care facilities to present options regarding available placement settings, including, in the case of individuals with cognitive disabilities, placement at privately run facilities. The department shall emphasize that the goal of these meetings is informed parental or guardian choice regarding factors such as quality of care, cost and efficiency and active treatment. For individuals who are served by state intermediate care facilities for the mentally retarded, the department shall inform the parents and guardians that closure of these facilities is a possibility in the future and shall ask parents and guardians for their input on possible closure. The department shall complete these meetings on or before November 15, 2011.**

B. **On or before December 1, 2011, the department shall submit a written report to the governor, the speaker of the house of representatives and the president of the senate regarding meetings held pursuant to subsection A, including recommendations relating to the closure of the state**

intermediate care facilities for the mentally retarded. The department shall provide the secretary of state with a copy of this report."

Amend title to conform

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1190

Introduced by: Senators Gray: Barto, Klein, Murphy

AN ACT

AMENDING SECTION 36-554, ARIZONA REVISED STATUTES; RELATING TO DEVELOPMENTAL DISABILITIES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-554, Arizona Revised Statutes, is amended to read:

START_STATUTE36-554. Powers and duties of director

A. **The director shall:**

1. **Be responsible for developing and annually revising a statewide plan and initiating statewide programs and ~~service~~ SERVICES for the developmentally disabled in locations where the programs and services are necessary, which shall include:**
   a) **Child services, which may include infant stimulation, developmental training for ~~pre-school~~ PRESCHOOL children and special education at Arizona training program facilities for school-age, developmentally disabled children residing at Arizona training program facilities who do not attend public school.**
   b) **Adult services, in coordination with the vocational rehabilitation services of the department, which may include, ~~but not be limited to~~ FOR EXAMPLE, job training and training and adjustment services, job development and placement, sheltered employment and other nonvocational day activity services for adults.**
   c) **Residential services, including various community residential settings, Arizona training program facilities and state operated service centers ~~which~~ THAT provide varying levels of supervision in accordance with the developmental disability levels of the persons placed at such settings, facilities or centers. The department shall contract with private profit or nonprofit agencies to provide appropriate residential settings for developmentally disabled persons ~~which~~ THAT provide for regular assistance and supervision of such persons and ~~which~~ THAT provide varied developmental disability programs and services on or near the community residential setting.**
   d) **Resource services, which may include comprehensive evaluation services, information and referral services and outpatient rehabilitation and social development services. The department, in providing developmental disability programs and services ~~shall~~ AND whenever practicable, ~~utilize~~ SHALL USE qualified private contractors. In selecting private contractors, the department shall ~~utilize~~ USE those contractors ~~which~~ THAT can clearly demonstrate an ability to perform ~~such~~ THE contract in accordance with standards and specifications adopted by the department.**

2. **Establish standards, provide technical assistance~~,~~ and supervise all developmental disability programs and services operated by or supported by the department.**
3. **Coordinate the planning and implementation of developmental disability programs and activities, institutional and community, of all state agencies. ~~, provided this shall not be construed as depriving~~ THIS DOES NOT DEPRIVE other state agencies of jurisdiction over, or the right to plan for, control~~,~~ and operate programs that pertain to developmental disability programs but that fall within the primary jurisdiction of ~~such~~ THE other state agencies.**
4. **Periodically assess the effectiveness of the quality assurance system as required by 42 Code of Federal Regulations section 434.34 as it pertains to developmental disabilities programs.**
5. **License community residential settings pursuant to this chapter.**
6. **Develop rules establishing a procedure for handling complaints about community residential settings.**
7. **Inform in writing every parent or guardian of a developmentally disabled client residing at or transferring to a community residential setting of the complaint handling procedure.**
8. **As new community residential settings are developed over a period of time, reduce the clientele at Arizona training program facilities to those developmentally disabled persons who are required to be in Arizona training program facilities because the community lacks an appropriate community residential setting that meets their individual needs or whose parents or legal guardians want them in an Arizona training program facility.**
9. **In conjunction with the division, individuals with developmental disabilities and their families, advocates, community members and service providers, develop, enhance and support environments that enable individuals with developmental disabilities to achieve and maintain physical well-being, personal and professional satisfaction, participation as family and community members and safety from abuse and exploitation.**
10. **Do all other things reasonably necessary and proper to carry out the duties ~~and the provisions~~ of this chapter.**
11. **Adopt rules regarding procurement procedures similar to those found in title 41, chapter 23.**
12. **PLACE PERSONS WITH DEVELOPMENTAL DISABILITIES WHO RESIDE IN ONE OF THE FOUR PHOENIX-BASED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED THAT ARE OPERATED BY THIS STATE INTO EXISTING GROUP HOMES AND PRIVATE, NONPROFIT INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED IN THIS STATE. IN MAKING PLACEMENT DECISIONS, THE DIRECTOR SHALL REQUEST AND USE INPUT FROM PARENTS, FAMILY MEMBERS AND GUARDIANS OF THE DEVELOPMENTALLY DISABLED PERSONS.**

B. **Programs and services offered pursuant to subsection A, paragraph 1 ~~of this section~~ shall be provided in cooperation with public and private resources that can best meet the needs of developmentally disabled persons and that are located in the community and in proximity to the persons being served.**

C. **The director may:**
1. **Establish nonresidential outpatient programs for placement, evaluation, care, treatment and training of developmentally disabled persons residing in the community who are not eligible for public school programs~~,~~ and who do not have access to other state supported programs providing equivalent services.**
2. **Develop cooperative programs with other state departments and agencies, political subdivisions of the state~~,~~ and private agencies concerned with and providing services for the developmentally disabled.**

3. **Contract for the purchase of services with other state and local governmental or private agencies. Such agencies are authorized to accept and expend funds received pursuant to such contracts.**
4. **Stimulate research by public and private agencies, institutions of higher learning~~,~~ and hospitals in the interest of the prevention of developmental disabilities and improved methods of care and training for the developmentally disabled.**
5. **Apply for, accept, receive, hold in trust or use in accordance with the terms of the grant or agreement any public or private funds or properties, real or personal, granted or transferred to it for any purpose authorized by this chapter.**
6. **Make and amend rules from time to time as deemed necessary for the proper administration of programs and services for the treatment of developmentally disabled persons, for the admission of developmentally disabled persons to the programs and services and to carry out the purposes of this chapter. END_STATUTE**

Sec. 2. Closure of state intermediate care facilities for persons with developmental disabilities; client transfer; report

A. **The department of economic security shall close the four state-operated intermediate care facilities for the mentally retarded in Phoenix within three months after the effective date of this act.**
B. **Within thirty days after the effective date of this act, the director of the department of economic security shall prepare an action plan for the related closure of the four Phoenix-based intermediate care facilities. The director shall provide a copy of this action plan to the governor, the president of the senate, the speaker of the house of representatives, the chairpersons of the senate and house of representatives appropriations committees and the director of the joint legislative budget committee. The action plan must identify all of the tasks to be completed, the title of the person responsible for each task and the required task completion date.**
C. **The department shall transfer the developmentally disabled individuals who reside in the four facilities to existing group home vacancies and private nonprofit intermediate care facilities for the mentally retarded.**
D. **The department shall base its decision to transfer a client to an existing group home vacancy or a private nonprofit facility on the wishes of the client's parent or guardian.**
E. **After all clients have been transferred, the department shall sell the facilities and deposit the proceeds of the sale in the state general fund.**
F. **The department shall make all reasonable efforts to protect the clients' health and safety during the transition process.**
G. **Not later than nine months after the facilities are closed and all clients have been transferred, the director of the department of economic security shall submit to the governor, the president of the senate, the speaker of the house of representatives, the chairpersons of the senate and house of representatives appropriations committees and the director of the joint legislative budget committee a written report relating to the financial and programmatic success of the closure of the facilities.**

AMENDED

ARIZONA STATE SENATE
RESEARCH STAFF

AMBER O'DELL
LEGISLATIVE RESEARCH ANALYST
PUBLIC SAFETY &

HUMAN SERVICES COMMITTEE
Telephone: (602) 926 -3171
Facsimile: (602) 926 -3833

TO: MEMBERS OF THE SENATE
DATE: February 18, 2011
SUBJECT: Strike everything amendment to S.B. 1190, relating to developmental disabilities; residential placement

Purpose

Requires the Department of Economic Security (DES) to hold meetings with parents and guardians of developmentally disabled individuals living in certain institutional settings to present placement options.

Background

According to DES, the Division of Developmental Disabilities (DDD) provides services and programs to 30,667 people with developmental disabilities as of June 30, 2010. To be eligible for DDD services, a person must have a chronic disability that is manifested before the age of 18 and is attributable to a cognitive disability, cerebral palsy, epilepsy or autism. The person also must have substantial limitations in specified life functions. Individuals with developmental disabilities who qualify for services through DDD may also be eligible for services through the Arizona Long Term Care System (ALTCS), which provides long term and acute care services to individuals with developmental disabilities who are at risk of institutionalization and who meet financial eligibility criteria.

DDD provides services in a variety of living environments. According to DES, as of June 30, 2010, a total of 201 clients lived in institutional settings, which consist of nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs). A *nursing facility* is a Medicaid certified facility that provides inpatient room, board and nursing services to individuals who need them on a continuous basis but do not require hospital care or direct daily care from a physician. An *ICF/MR* is a facility whose primary purpose is to provide health, habilitative, and rehabilitative services to people who require them on a continuous basis. There are five ICF/MRs in Phoenix, four of which are operated by DDD. Approximately 30 people currently reside in those four facilities.

According to the Joint Legislative Budget Committee (JLBC), the budget includes $16,604,700 and 77.7 FTE Positions for Institutional Services in FY 2011. These amounts consist of approximately $4.2 million from the General Fund and $12.4 million from the Long Term Care System Fund. Those amounts consist of an increase for anticipated caseload growth, and is estimated to serve 249 clients. There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

1. Requires DES to conduct meetings with the parents and guardians of individuals with cognitive or developmental disabilities who are served by state ICF/MRs, skilled nursing facilities or intermediate care facilities to present options regarding available placement settings, including, in the case of individuals with cognitive disabilities, placement at privately run facilities.
2. Requires DES to emphasize that the goal of the meetings is informed parental or guardian choice regarding factors such as quality of care, cost, efficiency and active treatment.

3. Requires DES to inform parents and guardians of individuals who are served by state ICF/MRs that closure of the facilities is a possibility in the future and requires DES to ask the parents and guardians for their input on possible closure.
4. Requires DES to complete the meetings by November 15, 2011.
5. Requires DES to submit, by December 1, 2011, a written report to the Governor, the Speaker of the House of Representatives, the President of the Senate and the Secretary of State regarding the meetings, including recommendations relating to the closure of that state ICF/MRs.
6. Becomes effective on the general effective date.

Amendments Adopted by Committee

· Adopted the strike everything amendment.

Senate Action

PSHS 2/16/11 DPA/SE 5-0-1-0

Assigned to HEALTH FOR COMMITTEE

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1357

AHCCCS; missed appointments; provider remedy

Purpose

Allows a physician or primary care provider (PCP) to prohibit a member of the Arizona Health Care Cost Containment System (AHCCCS) from rescheduling an appointment until the AHCCCS member pays a missed appointment fee, if the appointment was not cancelled in advance.

Background

The AHCCCS Administration is responsible for administering Arizona's Medicaid program, which includes both acute medical care and long-term care services. For its acute care members, the AHCCCS Administration contracts with health plans to provide coverage. The health plans, in turn, negotiate rates of service and contract with physicians and other providers to deliver care.

Federal Medicaid requirements limit the level and type of cost-sharing that providers may charge to AHCCCS members. AHCCCS Administration rules outline standards for payments and charges (R9-22-702). The rules currently state that an AHCCCS provider may not charge more than the actual, reasonable cost of providing a service. Additionally, a provider may charge, submit a claim to or demand or collect payment from an AHCCCS member only as follows: a) to collect an authorized copayment; b) to recover a duplicative payment made by a third party, if payment is not assigned to the health plan contractor; and c) to obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or provided inaccurate information that caused payment to the provider to be reduced or denied.

To date, the AHCCCS Administration has been advised by the Centers for Medicare and Medicaid Services (CMS) that charging a fee for a missed appointment is in conflict with federal law that prohibits the imposition of cost-sharing on traditional Medicaid populations.

The fiscal impact associated with this legislation is unknown.

Provisions

1. Authorizes physicians or PCPs who provide acute care services to AHCCCS members to charge a $25 fee to an AHCCCS member if the member misses an appointment and does not cancel the appointment in advance.
2. Permits the physician or PCP to prohibit the AHCCCS member from rescheduling until the $25 fee is paid.
3. Becomes effective on the general effective date.

REFERENCE TITLE: AHCCCS; missed appointments; provider remedy

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1357

Introduced by: Senator Antenori; Representatives Gowan, Harper, Stevens, Vogt: Senators Allen, Crandall, Driggs, Gould, Gray, Griffin, Klein, Melvin, Nelson, Reagan, Shooter, Smith, Yarbrough; Representative Montenegro

AN ACT

AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2930; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2930, to read:
START_STATUTE36-2930. Members; missed medical appointments; provider remedy
IF A MEMBER MISSES A SCHEDULED APPOINTMENT WITH A PHYSICIAN OR PRIMARY CARE PRACTITIONER WHO PROVIDES MEDICAL SERVICES PURSUANT TO THIS ARTICLE WITHOUT CANCELING THE APPOINTMENT BEFORE THE TIME FOR WHICH IT IS SCHEDULED, THE PHYSICIAN OR PRIMARY CARE PRACTITIONER MAY PROHIBIT THE MEMBER FROM RESCHEDULING UNTIL THE MEMBER HAS PAID A TWENTY-FIVE DOLLAR MISSED APPOINTMENT FEE TO THE PROVIDER.
END_STATUTE

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1405

hospital admissions; restrictions

Purpose

Requires an admissions officer of a hospital to verify a person's citizenship or legal status before admitting the person for nonemergency care. Specifies methods for verification and requires the admissions officer to contact the local federal immigration office if a person does not meet citizenship or legal status requirements.

Background

The Arizona Department of Health Services (DHS) licenses hospitals and other health care institutions in Arizona. DHS rules define a *hospital* as a health care institution that provides, through an organized medical staff, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients (R9-10-201). In addition to other licensing requirements, hospitals must comply with certain admissions procedures. According to DHS rules, a hospital must adhere to the following admissions requirements to receive a state operating license: a) a patient is admitted only on the order of a medical staff member; b) an authorized individual is available at all times to accept a patient for admission; c) except in an emergency, the hospital obtains informed consent from a patient or the patient's representative before or at the time of admission; d) informed consent is documented in the patient's medical record; e) a physician or other medical staff member performs a medical history and physical exam on a patient within 30 days before admission or within 48 hours after admission, and documents the medical history and physical exam in the patient's medical record within 48 hours of admission; and f) if a physician or medical staff member performs a medical history and physical exam on a patient before admission, the physician or the medical staff member enters an interval note into the patient's medical record at the time of admission (R9-10-210).

Pursuant to the federal Emergency Medical Treatment and Labor Act (EMTALA), hospitals that participate in Medicare are required to screen individuals who present in emergency departments to determine if the person has an emergency medical condition, regardless of the person's ability to pay or legal status. EMTALA also requires hospitals to provide treatment necessary to stabilize the patient and to arrange for transfer of the patient if the hospital is unable to stabilize the patient, or if the patient requests. Hospitals and physicians (including on-call physicians) that provide services in participating hospitals are subject to civil penalties and, in certain cases, exclusion from Medicare for violations of EMTALA.

The fiscal impact associated with this legislation is unknown.

Provisions

1. Requires the admissions officer of a hospital, before admitting a person for nonemergency care, to confirm the person is a citizen, a legal resident of or lawfully present in the United States.
2. Authorizes the admissions officer to use any of the following to verify citizenship or legal status:
   a) an Arizona driver license issued after 1996 or an Arizona non-operating identification license;
   b) a birth certificate or delayed birth certificate issued in any state, territory or possession of the United States;
   c) a United States certificate of birth abroad;

d) a United States passport;
e) a foreign passport with a United States visa;
f) an I-94 form with a photograph;
g) a United States citizenship and immigration services employment authorization document or refugee travel document;
h) a United States certificate of naturalization;
i) a United States certificate of citizenship;
j) a tribal certificate of Indian blood; or
k) a tribal or Bureau of Indian affairs affidavit of birth.

3. Requires the admissions officer to contact the local federal immigration office if the person does not meet citizenship or legal status requirements.
4. Requires the admissions officer, if a hospital provides emergency care to a person who does not meet citizenship or legal status requirements, to contact the local federal immigration office upon the patient's successful treatment.
5. States a hospital that complies with the requirements of this legislation is not subject to civil liability.
6. Becomes effective on the general effective date.

REFERENCE TITLE: hospital admissions; restrictions

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1405

Introduced by: Senators Smith: Biggs, Griffin, Klein, Melvin, Pearce R, Shooter

AN ACT

AMENDING TITLE 36, CHAPTER 4, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-415; RELATING TO HEALTH CARE INSTITUTIONS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Title 36, chapter 4, article 1, Arizona Revised Statutes, is amended by adding section 36-415, to read:
START_STATUTE36-415. Hospital admissions; proof of citizenship, legal residence or lawful presence; immunity

A. **BEFORE A HOSPITAL ADMITS A PERSON FOR NONEMERGENCY CARE, A HOSPITAL ADMISSIONS OFFICER MUST CONFIRM THAT THE PERSON IS A CITIZEN OF THE UNITED STATES, A LEGAL RESIDENT OF THE UNITED STATES OR LAWFULLY PRESENT IN THE UNITED STATES. THE ADMISSIONS OFFICER MAY USE ANY METHOD PRESCRIBED IN SECTION 1-501 TO VERIFY CITIZENSHIP OR LEGAL STATUS.**

B. **IF THE ADMISSIONS OFFICER DETERMINES THAT THE PERSON DOES NOT MEET THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION, THE ADMISSIONS OFFICER MUST CONTACT THE LOCAL FEDERAL IMMIGRATION OFFICE.**

C. **IF THE HOSPITAL PROVIDES EMERGENCY MEDICAL CARE PURSUANT TO FEDERAL REQUIREMENTS TO A PERSON WHO DOES NOT MEET THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION, ON SUCCESSFUL TREATMENT OF THE PATIENT THE ADMISSIONS OFFICER MUST CONTACT THE LOCAL FEDERAL IMMIGRATION OFFICE.**

D. **A HOSPITAL THAT COMPLIES WITH THE REQUIREMENTS OF THIS SECTION IS NOT SUBJECT TO CIVIL LIABILITY.**

END_STATUTE

ARIZONA STATE SENATE
RESEARCH STAFF

GARTH KAMP
LEGISLATIVE RESEARCH ANALYST
JUDICIARY COMMITTEE
Telephone: (602) 926 -3171
Facsimile: (602) 926 -3833

TO: MEMBERS OF THE SENATE APPROPRIATIONS COMMITTEE
DATE: February 18, 2011
SUBJECT: Strike everything amendment to S.B. 1405, relating to restrictions; hospital admissions

Purpose

Requires an admissions officer or representative of a hospital to confirm a person's citizenship or legal status during the course of admission or treatment if the person cannot provide valid health insurance information. Specifies methods for verification and details reporting requirements if citizenship or legal status cannot be verified. Specifies disciplinary action for hospital noncompliance with verification requirements.

Background

The Arizona Department of Health Services (DHS) licenses hospitals and other health care institutions in Arizona. DHS rules define a *hospital* as a health care institution that provides, through an organized medical staff, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients (R9-10-201). In addition to other licensing requirements, hospitals must comply with certain admissions procedures. According to DHS rules, a hospital must adhere to the following admissions requirements to receive a state operating license: a) a patient is admitted only on the order of a medical staff member; b) an authorized individual is available at all times to accept a patient for admission; c) except in an emergency, the hospital obtains informed consent from a patient or the patient's representative before or at the time of admission; d) informed consent is documented in the patient's medical record; e) a physician or other medical staff member performs a medical history and physical exam on a patient within 30 days before admission or within 48 hours after admission, and documents the medical history and physical exam in the patient's medical record within 48 hours of admission; and f) if a physician or medical staff member performs a medical history and physical exam on a patient before admission, the physician or the medical staff member enters an interval note into the patient's medical record at the time of admission (R9-10-210).

Pursuant to the federal Emergency Medical Treatment and Labor Act (EMTALA), hospitals that participate in Medicare are required to screen individuals who present in emergency departments to determine if the person has an emergency medical condition, regardless of the person's ability to pay or legal status. EMTALA also requires hospitals to provide treatment necessary to stabilize the patient and to arrange for transfer of the patient if the hospital is unable to stabilize the patient, or if the patient requests. Hospitals and physicians (including on-call physicians) that provide services in participating hospitals are subject to civil penalties and, in certain cases, exclusion from Medicare for violations of EMTALA.

The fiscal impact associated with this legislation is unknown.

Provisions

1. Requires a hospital admissions officer or representative to confirm, at some point during the course of admission or treatment for emergency or nonemergency care, that the person is a citizen, legal resident or lawfully present in the United States if the person cannot provide valid health insurance information.
2. Authorizes the admissions officer or representative to use any of the following to verify citizenship or legal status:
   a) an Arizona driver license issued after 1996 or an Arizona non-operating identification license;
   b) a birth certificate or delayed birth certificate issued in any state, territory or possession of the United States;
   c) a United State s certificate of birth abroad;
   d) a United States passport;
   e) a foreign passport with a United States visa;
   f) an I-94 form with a photograph;
   g) a United States citizenship and immigration services employment authorization document or refugee travel document;
   h) a United States certificate of naturalization;
   i) a United States certificate of citizenship;
   j) a tribal certificate of Indian blood; or
   k) a tribal or Bureau of Indian affairs affidavit of birth.
3. Requires the admissions officer or representative to immediately contact the local federal immigration office or a local law enforcement agency to report the incident if the patient's citizenship or legal status cannot be verified.
4. Requires a hospital to submit an annual report to DHS to document compliance with the verification requirements and specifies report content requirements.
5. Specifies that a hospital that does not comply with the verification requirements is subject to disciplinary action against its license by DHS.
6. States that a hospital that complies with the requirements of this legislation is not subject to civil liability.
7. Becomes effective on the general effective date.

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1405

hospital admissions; restrictions

Purpose

Requires an admissions officer of a hospital to verify a person's citizenship or legal status before admitting the person for nonemergency care. Specifies methods for verification and requires the admissions officer to contact the local federal immigration office if a person does not meet citizenship or legal status requirements.

Background

The Arizona Department of Health Services (DHS) licenses hospitals and other health care institutions in Arizona. DHS rules define a *hospital* as a health care institution that provides, through an organized medical staff, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients (R9-10-201). In addition to other licensing requirements, hospitals must comply with certain admissions procedures. According to DHS rules, a hospital must adhere to the following admissions requirements to receive a state operating license: a) a patient is admitted only on the order of a medical staff member; b) an authorized individual is available at all times to accept a patient for admission; c) except in an emergency, the hospital obtains informed consent from a patient or the patient's representative before or at the time of admission; d) informed consent is documented in the patient's medical record; e) a physician or other medical staff member performs a medical history and physical exam on a patient within 30 days before admission or within 48 hours after admission, and documents the medical history and physical exam in the patient's medical record within 48 hours of admission; and f) if a physician or medical staff member performs a medical history and physical exam on a patient before admission, the physician or the medical staff member enters an interval note into the patient's medical record at the time of admission (R9-10-210).

Pursuant to the federal Emergency Medical Treatment and Labor Act (EMTALA), hospitals that participate in Medicare are required to screen individuals who present in emergency departments to determine if the person has an emergency medical condition, regardless of the person's ability to pay or legal status. EMTALA also requires hospitals to provide treatment necessary to stabilize the patient and to arrange for transfer of the patient if the hospital is unable to stabilize the patient, or if the patient requests. Hospitals and physicians (including on-call physicians) that provide services in participating hospitals are subject to civil penalties and, in certain cases, exclusion from Medicare for violations of EMTALA.

The fiscal impact associated with this legislation is unknown.

Provisions

1. Requires the admissions officer of a hospital, before admitting a person for nonemergency care, to confirm the person is a citizen, a legal resident of or lawfully present in the United States.
2. Authorizes the admissions officer to use any of the following to verify citizenship or legal status:
   a) an Arizona driver license issued after 1996 or an Arizona non-operating identification license;
   b) a birth certificate or delayed birth certificate issued in any state, territory or possession of the United States;
   c) a United States certificate of birth abroad;
   d) a United States passport;
   e) a foreign passport with a United States visa;
   f) an I-94 form with a photograph;
   g) a United States citizenship and immigration services employment authorization document or refugee travel document;

h) a United States certificate of naturalization;
i) a United States certificate of citizenship;
j) a tribal certificate of Indian blood; or
k) a tribal or Bureau of Indian affairs affidavit of birth.

3. Requires the admissions officer to contact the local federal immigration office if the person does not meet citizenship or legal status requirements.
4. Requires the admissions officer, if a hospital provides emergency care to a person who does not meet citizenship or legal status requirements, to contact the local federal immigration office upon the patient's successful treatment.
5. States a hospital that complies with the requirements of this legislation is not subject to civil liability.
6. Becomes effective on the general effective date.

Fiftieth Legislature, First Regular Session
Appropriations
S.B. 1405

PROPOSED AMENDMENT
SENATE AMENDMENTS TO S.B. 1405
(Reference to printed bill)

Page 1, line 4, after the period strike remainder of line
Line 5, strike "residence or lawful presence" insert "Hospitals; patients; verification and reporting requirements; disciplinary action"
Line 6, strike "BEFORE A HOSPITAL ADMITS" insert "IF"; strike "FOR" insert "WHO SEEKS OR IS RECEIVING EMERGENCY OR"; after "NONEMERGENCY" insert "MEDICAL"; after "CARE" insert "AT"; after "HOSPITAL" insert "CANNOT PROVIDE VALID HEALTH INSURANCE INFORMATION, THE HOSPITAL"
Line 7, after "OFFICER" insert "OR REPRESENTATIVE"; after "CONFIRM" insert "AT SOME POINT DURING THE COURSE OF THE PERSON'S ADMISSION OR TREATMENT"
Line 9, after "OFFICER" insert "OR REPRESENTATIVE"
Line 11, after "OFFICER" strike remainder of line
Line 12, strike "THE REQUIREMENTS OF" insert "OR REPRESENTATIVE CANNOT VERIFY THE PATIENT'S CITIZENSHIP OR LEGAL STATUS AS REQUIRED PURSUANT TO"; after "OFFICER" insert "OR REPRESENTATIVE"; after "MUST" insert "IMMEDIATELY"
Line 13, after "OFFICE" insert "OR A LOCAL LAW ENFORCEMENT AGENCY TO REPORT THE INCIDENT"
Strike lines 14 through 17 and insert:

C. **"A HOSPITAL MUST SUBMIT AN ANNUAL REPORT TO THE DEPARTMENT TO DOCUMENT ITS COMPLIANCE WITH THE REQUIREMENTS OF THIS SECTION IN A MANNER AND FORM PRESCRIBED BY THE DEPARTMENT. EACH REPORT MUST INCLUDE DOCUMENTATION REGARDING THE NUMBER OF REFERRALS TO IMMIGRATION AND LAW ENFORCEMENT PURSUANT TO SUBSECTION B OF THIS SECTION."**
D. **"A HOSPITAL THAT DOES NOT COMPLY WITH THE REQUIREMENTS OF THIS SECTION IS SUBJECT TO DISCIPLINARY ACTION AGAINST ITS LICENSE BY THE DEPARTMENT."**

Reletter to conform
Amend title to conform

STEVE SMITH

REFERENCE TITLE: palliative care; patient information

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1447

Introduced by: Senators Lopez: Jackson; Representatives Farley, Heinz, Miranda C

AN ACT

AMENDING TITLE 32, CHAPTER 32, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 3; RELATING TO PALLIATIVE CARE PATIENT INFORMATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Title 32, chapter 32, Arizona Revised Statutes, is amended by adding article 3, to read:

ARTICLE 3. PALLIATIVE CARE PATIENT INFORMATION
START_STATUTE32-3241. Definitions
IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. **"APPROPRIATE" MEANS CONSISTENT WITH APPLICABLE LEGAL, HEALTH AND PROFESSIONAL STANDARDS, THE PATIENT'S CLINICAL AND OTHER CIRCUMSTANCES AND THE PATIENT'S REASONABLY KNOWN WISHES AND BELIEFS.**
2. **"ATTENDING HEALTH CARE PRACTITIONER" MEANS A PHYSICIAN WHO IS LICENSED PURSUANT TO CHAPTER 13 OR 17 OF THIS TITLE, OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO CHAPTER 15 OF THIS TITLE, AND WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE AND TREATMENT OF THE PATIENT.**
3. **"PALLIATIVE CARE" MEANS HEALTH CARE TREATMENT, INCLUDING INTERDISCIPLINARY END-OF-LIFE CARE AND CONSULTATION WITH PATIENTS AND FAMILY MEMBERS, TO PREVENT OR RELIEVE PAIN AND SUFFERING AND TO ENHANCE THE PATIENT'S QUALITY OF LIFE. PALLIATIVE CARE INCLUDES HOSPICE CARE.**
4. **"TERMINAL ILLNESS OR CONDITION" MEANS AN ILLNESS OR CONDITION THAT CAN REASONABLY BE EXPECTED TO CAUSE DEATH WITHIN SIX MONTHS, WHETHER OR NOT TREATMENT IS PROVIDED.**

END_STATUTE

START_STATUTE32-3242. Terminally ill patients; palliative care; attending health care practitioner responsibilities

A. **IF A PATIENT IS DIAGNOSED WITH A TERMINAL ILLNESS OR CONDITION, THE PATIENT'S ATTENDING HEALTH CARE PRACTITIONER SHALL OFFER TO**

PROVIDE THE PATIENT WITH INFORMATION AND COUNSELING REGARDING PALLIATIVE CARE AND END-OF-LIFE OPTIONS APPROPRIATE TO THE PATIENT, INCLUDING:

1. **THE RANGE OF OPTIONS APPROPRIATE TO THE PATIENT.**
2. **THE PROGNOSIS, RISKS AND BENEFITS OF THE VARIOUS OPTIONS.**
3. **THE PATIENT'S LEGAL RIGHTS TO COMPREHENSIVE PAIN AND SYMPTOM MANAGEMENT AT THE END OF LIFE.**

B. **THE ATTENDING HEALTH CARE PRACTITIONER MAY PROVIDE THE INFORMATION REQUIRED PURSUANT TO THIS SECTION ORALLY OR IN WRITING.**

C. **IF THE PATIENT LACKS CAPACITY TO REASONABLY UNDERSTAND AND MAKE INFORMED CHOICES RELATING TO PALLIATIVE CARE, THE ATTENDING HEALTH CARE PRACTITIONER SHALL PROVIDE INFORMATION AND COUNSELING REQUIRED PURSUANT TO THIS SECTION TO A PERSON WHO HAS THE AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR THE PATIENT.**

D. **THE ATTENDING HEALTH CARE PRACTITIONER MAY ARRANGE FOR INFORMATION AND COUNSELING REQUIRED PURSUANT TO THIS SECTION TO BE PROVIDED BY ANOTHER PROFESSIONALLY QUALIFIED INDIVIDUAL.**

E. **IF THE ATTENDING HEALTH CARE PRACTITIONER IS NOT WILLING TO PROVIDE THE PATIENT WITH INFORMATION AND COUNSELING REQUIRED PURSUANT TO THIS SECTION, THE ATTENDING HEALTH CARE PRACTITIONER SHALL ARRANGE FOR ANOTHER HEALTH CARE PRACTITIONER TO DO SO OR SHALL REFER OR TRANSFER THE PATIENT TO ANOTHER ATTENDING HEALTH CARE PRACTITIONER WILLING TO DO SO.**

F. **IF MORE THAN ONE PHYSICIAN OR NURSE PRACTITIONER SHARE PRIMARY RESPONSIBILITY FOR THE CARE AND TREATMENT OF THE PATIENT, EACH OF THEM HAS RESPONSIBILITY TO PROVIDE THE INFORMATION REQUIRED PURSUANT TO THIS SECTION UNLESS THEY AGREE TO ASSIGN THAT RESPONSIBILITY TO ONLY ONE OF THEM.**

END_STATUTE

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1519

AHCCCS; termination

Purpose

An emergency measure that terminates the Arizona Health Care Cost Containment System (AHCCCS) Administration. Appropriates monies to the Department of Health Services (DHS) to provide services to the medically indigent, the developmentally disabled and persons who receive behavioral health services.

Background

The passage of Title XIX of the Social Security Act in 1965 created the federal Medicaid program, which is the nation's health insurance program for persons with little or no income. Medicaid

pays for medical assistance for eligible individuals and families and is jointly funded by the federal and state governments. Medicaid operates as an entitlement program; thus, individuals who meet specified eligibility requirements are entitled to Medicaid services.

The federal government developed extensive federal guidelines for the program and, in Arizona, has traditionally paid for approximately two-thirds of the costs of the program. The current federal match rate is approximately three-fourths due to the enhanced FMAP provided in the American Reinvestment and Recovery Act. Within the federal guidelines, states may develop their own standards for eligibility, services provided and rates of payment. States are responsible for administering the program. Arizona first chose not to participate in the Medicaid program, instead relying on the counties to provide indigent health care on a county by county basis.

By establishing AHCCCS in 1981, the Legislature sought to bring federal Medicaid dollars into the state to relieve the burden of the growing cost of health care. On October 1, 1982, Arizona became the last state in the nation to implement a Medicaid program, and the first to implement a statewide, Medicaid managed care system using prepaid, capitated arrangements with contracted health plans.

Originally, AHCCCS provided only acute care services. In 1987, the Legislature created the Arizona Long Term Care System (ALTCS). AHCCCS implemented long-term care services in a two-phase process: persons who were developmentally disabled began receiving services in December 1988 and services for the elderly and physically disabled were added in January 1989.

AHCCCS began phasing in behavioral health services in 1990 when Congress mandated that all states offer behavioral health services for Medicaid members under the age of 21 years. The phase-in of behavioral health for all Medicaid eligible members was completed in October 1995.

In November 2000, voters passed Proposition 204, which expanded the eligibility for AHCCCS to all persons with income under 100 percent of the federal poverty level (FPL). Previously, AHCCCS had provided services to some of these individuals using state dollars only. The federal government agreed to provide federal matching funds, and coverage of this population was fully implemented in October 2001.

After eliminating AHCCCS, there is an estimated savings of approximately $1.94 billion to the state GF over nine months. If the Legislature follows through on the legislative intent presented in this legislation, after reallocating certain monies to specified programs, there is an estimated $1 billion in state GF savings. There is an estimated loss of approximately $4.8 billion in federal matching monies.

Provisions

1. Terminates the AHCCCS Administration and AHCCCS programs beginning October 1, 2011, and repeals all related statutes.
2. States that, subject to the availability of appropriated monies, beginning October 1, 2011, DHS is to implement a program to provide services to the medically indigent (Program).
3. Stipulates the Program shall include services prescribed by rules developed by DHS to include services to the developmentally disabled and individuals receiving behavioral health services under the current AHCCCS statutes.
4. Requires the rules adopted by DHS to include:
   a) a reinsurance system that is modeled after reinsurance prescribed by the AHCCCS Administration; and
   b) the use of the private sector to deliver the services.
5. States legislative intent that the savings realized through the termination of AHCCCS are distributed to DHS as follows, in addition to other appropriations:

a) $200 million for behavioral health services;
b) $200 million for services to the developmentally disabled;
c) $500 million for medical services to the medically indigent; and
d) $900 million to the state GF.

6. Exempts DHS from the rule making process for two years after the effective date of this act.
7. Directs Legislative Council to prepare proposed legislation to conform statute to this act for consideration in the Fiftieth Legislature, Second Regular Session.
8. Contains an emergency clause.
9. Becomes effective on signature of the Governor, if the emergency clause is enacted.

ARIZONA STATE SENATE
Fiftieth Legislature, First Regular Session

FACT SHEET FOR S.B. 1553

education; Arizona empowerment accounts

Purpose

Establishes and prescribes rules and requirements for the Arizona Empowerment Accounts program for special education students.

Background

Pursuant to A.R.S. § 15-763, all school districts and charter schools are required to develop policies for providing special education to all children with disabilities. The governing board of each school district is required to make such programs and services available to all eligible children under the age of twenty two.

Current statute also allows tuition tax credits for corporations donating to school tuition organizations (STO) that give scholarships to disabled or displaced students. Statute requires at least 90 percent of the monies from corporate tuition tax credits go to educational scholarships or tuition grants for qualified students. Any student who receives an educational scholarship from a STO is allowed to attend any qualified school chosen by the parents or guardians.

There may be a fiscal impact to the state General Fund associated with this legislation.

Provisions

Arizona Empowerment Accounts

Establishes Arizona Empowerment Accounts to provide educational options for special education students..

1. Requires the State of Arizona to deposit monies to each Empowerment Account equal to ninety per cent of state aid that would otherwise be allocated for a student and computed using all state funding weights.
2. Requires a parent of a qualified student to sign a written agreement in order for their child to receive an Empowerment Account. The parent must agree to:
   a) Ensure the student receives instruction in reading, math, social studies and science;

b) Remove the qualified student from a governmental district or charter school;
c) Not accept scholarships from any STO;
d) Use deposited Empowerment Account monies only for school related expenses.

3. Specifies that receiving an Arizona Empowerment Account satisfies statutory school attendance requirements.
4. Requires parents to renew a student's Empowerment Account annually.
5. Prohibits a qualified school or service provider from sharing, refunding or rebating any Arizona Empowerment Account monies to the parent or qualified student.

Empowerment Account Administration & Rules

6. Requires the Department of Revenue (DOR) to contract with private financial management firms to manage Arizona Empowerment Accounts.
7. Requires DOR to conduct or contract annual random sample audits of Empowerment Accounts.
8. Allows DOR to remove any parent or qualified student from the Arizona Empowerment Account program due to misuse of funds.
9. Allows a parent to appeal DOR's decision regarding their removal from the Arizona Empowerment Account program.
10. Permits DOR to refer cases concerning misuse of funds to the Attorney General for investigation.
11. Allows DOR to use up to three percent of each administered Empowerment Account for administration costs.
12. Mandates quarterly transfers of state aid monies to Empowerment Accounts under the direction of DOR.
13. Allows DOR to adopt rules relating to the administration of Empowerment Accounts.

State Control over Nonpublic Schools

14. Specifies that no government agency has control over any nonpublic or home school and that any qualified school that accepts Empowerment Account monies is not an agent of the state or federal government.
15. Allows a school to keep in place all practices, policies, creeds and curriculum in order to be defined as a qualified school and accept Empowerment Account monies.
16. Specifies that in any legal proceeding challenging the application of this act, the state bears the burden of establishing that the law is necessary and does not impose any undue burden on qualified schools.

Definitions

17. Defines a *qualified student* as either: a resident of Arizona with a disability who is a full-time student attending a governmental primary or secondary school for at least 100 days of the prior fiscal year; or as a student who receives a scholarship from an STO intended for a student with a disability and continues to attend a qualified school.
18. Defines a *qualified school* as a nongovernmental preschool, primary or secondary school for handicapped students that is located in the state of Arizona.
19. Defines additional terms.
20. Becomes effective on the general effective date.

REFERENCE TITLE: AHCCCS; children; coverage

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2090

Introduced by: Representative Heinz

AN ACT

AMENDING SECTIONS 36-2912, 36-2982 AND 36-2986, ARIZONA REVISED STATUTES; REPEALING SECTIONS 36-2985 AND 42-5017, ARIZONA REVISED STATUTES; MAKING AN APPROPRIATION; RELATING TO THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 36-2912, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2912. Healthcare group coverage; program requirements for small businesses and public employers; related requirements; definitions

A. **The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). In counties with a population of less than five hundred thousand persons, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.**

B. **Employers with two eligible employees or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):**
   1. **May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.**
   2. **May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.**
   3. **Shall have a minimum of two and a maximum of fifty eligible employees at the effective date of their first contract with the administration.**

C. **The administration shall not enroll an employer group in healthcare group sooner than ninety days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the ninety day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.**

D. **Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:**
   1. **Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.**
   2. **Medical assistance is provided by a government subsidized health care program.**
   3. **Medical assistance is provided pursuant to section 36-2982, subsection ~~I~~ H.**

E. **An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.**

F. **An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.**

G. **Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.**

H. **The administration shall provide eligible employees with disclosure information about the health benefit plan.**

I. **The director shall:**

1. **Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).**
2. **Prohibit the administration and program contractors from reimbursing a noncontracting hospital for services provided to a member at a noncontracting hospital except for services for an emergency medical condition.**
3. **Require that a contractor, the administration or an accountable health plan negotiate reimbursement rates. The reimbursement rate for an emergency medical condition for a noncontracting hospital is:**
4. **In counties with a population of more than five hundred thousand persons, one hundred fourteen per cent of the reimbursement rates established pursuant to section 36-2903.01, subsection H. The hospital shall notify the contractor when a member is stabilized.**
    a) **In counties with a population of less than five hundred thousand persons, one hundred twenty-five per cent of the reimbursement rates established pursuant to section 36-2903.01, subsection H. The hospital shall notify the contractor when a member is stabilized.**
    b) **Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.**
5. **Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.**
6. **Adopt rules.**
7. **Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904.**

J. **With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last**

resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

K. **The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:**
   1. **Provisions of coverage relating to the following, if applicable:**
      a) **The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.**
      b) **Renewability of coverage.**
      c) **Any preexisting condition exclusion.**
      d) **The geographic areas served by the contractor.**
   2. **The benefits and premiums available under all health benefit plans for which the employer is qualified.**

L. **The administration shall describe the information required by subsection K of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:**
   1. **An outline of coverage that describes the benefits in summary form.**
   2. **The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.**
   3. **The minimum employer contribution and group participation rules that apply to any particular type of coverage.**
   4. **In the case of a network plan, a map or listing of the areas served.**

M. **A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.**

N. **At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.**

O. **The administration shall increase or decrease premiums based on actuarial reviews by an independent actuary of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. For each contract period the administration shall set premiums that in the aggregate cover projected medical and administrative costs for that contract period and that are determined pursuant to generally accepted actuarial principles and practices by an independent actuary.**

P. **The administration shall consider age, sex, health status-related factors, group size, geographic area and community rating when it establishes premiums for the healthcare group program.**

Q. **Except as provided in subsection R of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability. A health benefit plan shall not provide or offer any service, benefit or coverage that is not part of the health benefit plan contract.**

R. **A health benefit plan shall not exclude coverage for preexisting conditions, except that:**

1. **A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.**
2. **The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.**

S. **The contractor shall calculate creditable coverage according to the following:**
1. **The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.**
2. **The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.**
3. **The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.**

T. **The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period, the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.**

U. **The written certification provided by the administration must include:**
1. **The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.**
2. **Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.**

V. **The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:**
1. **The date that the certificate is issued.**
2. **The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.**
3. **The name, address and telephone number of the issuer providing the certificate.**
4. **The telephone number to call for further information regarding the certificate.**
5. **One of the following:**
    a) **A statement that the individual has at least eighteen months of creditable coverage. For the purposes of this subdivision, "eighteen months" means five hundred forty-six days.**

b) **Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.**

6. **The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.**

W. **The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance of the certification. Periods of creditable coverage for an individual are established by presentation of the certifications in this section.**

X. **The healthcare group program shall comply with all applicable federal requirements.**

Y. **Healthcare group may pay a commission to an insurance producer. To receive a commission, the producer must certify that to the best of the producer's knowledge the employer group has not had insurance in the ninety days before applying to healthcare group. For the purposes of this subsection, "commission" means a one time payment on the initial enrollment of an employer.**

Z. **On or before June 15 and November 15 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.**

AA. **The administration shall submit the following to the joint legislative budget committee:**

1. **Quarterly reports regarding the financial condition of the healthcare group program. The reports shall include the number of persons and employer groups enrolled in the program and medical loss information and projections.**
2. **An annual financial audit.**
3. **The analysis that is used to determine premiums pursuant to subsection O of this section.**

BB. ~~**Beginning July 1, 2009, and**~~ **Each fiscal year** ~~**thereafter**~~**, healthcare group shall limit employer group enrollment to not more than five per cent more than the number of employer groups enrolled in the program at the end of the preceding fiscal year. Healthcare group shall give enrollment priority to uninsured groups.**

CC. **For the purposes of this section:**

1. **"Accountable health plan" has the same meaning prescribed in section 20-2301.**
2. **"COBRA continuation provision" means:**
   a) **Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.**
   b) **Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974.**
   c) **Title XXII of the public health service act.**
   d) **Any similar provision of the law of this state or any other state.**
3. **"Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:**
   a) **An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.**
   b) **A church plan as defined in the employee retirement income security act of 1974.**
   c) **A health benefits plan, as defined in section 20-2301, issued by a health plan.**
   d) **Part A or part B of title XVIII of the social security act.**
   e) **Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.**
   f) **Title 10, chapter 55 of the United States Code.**

g) **A medical care program of the Indian health service or of a tribal organization.**
h) **A health benefits risk pool operated by any state of the United States.**
i) **A health plan offered pursuant to title 5, chapter 89 of the United States Code.**
j) **A public health plan as defined by federal law.**
k) **A health benefit plan pursuant to section 5(e) of the peace corps act (22 United States Code section 2504(e)).**
l) **A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).**
m) **A policy or contract issued by a health care insurer or the administration to a member of a bona fide association.**

4. **"Eligible employee" means a person who is one of the following:**
   a) **Eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).**
   b) **A person who works for an employer for a minimum of twenty hours per week or who is self-employed for at least twenty hours per week.**
   c) **An employee who elects coverage pursuant to section 36-2982, subsection ~~I~~ H. The restriction prohibiting employees employed by public agencies prescribed in section 36-2982, subsection ~~I~~ H does not apply to this subdivision.**
   d) **A person who meets all of the eligibility requirements, who is eligible for a federal health coverage tax credit pursuant to section 35 of the internal revenue code of 1986 and who applies for health care coverage through the healthcare group program. The requirement that a person be employed with a small business that elects healthcare group coverage does not apply to this eligibility group.**
5. **"Emergency medical condition" has the same meaning prescribed in the emergency medical treatment and active labor act (P.L. 99-272; 100 Stat. 164; 42 United States Code section 1395dd(e)).**
6. **"Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.**
7. **"Health benefit plan" means coverage offered by the administration for the healthcare group program pursuant to this section.**
8. **"Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health plan including:**
   a) **Health status.**
   b) **Medical condition, including physical and mental illness.**
   c) **Claims experience.**
   d) **Receipt of health care.**
   e) **Medical history.**
   f) **Genetic information.**
   g) **Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.**
   h) **The existence of a physical or mental disability.**
9. **"Hospital" means a health care institution licensed as a hospital pursuant to chapter 4, article 2 of this title.**
10. **"Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the**

health benefit plan if the initial enrollment period is at least thirty-one days. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent. An employee or dependent shall not be considered a late enrollee if:

a) **The person:**
   i. **At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefit plan.**
   ii. **Lost coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.**
   iii. **Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a COBRA continuation provision.**
   iv. **Requests enrollment within thirty-one days after the date of marriage.**

b) **The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period.**

c) **The person becomes a dependent of an eligible person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.**

11. **"Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.**
12. **"Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefit plan offered by a contractor.**
13. **"Small employer" means an employer who employs at least one but not more than fifty eligible employees on a typical business day during any one calendar year.**
14. **"Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.**

END_STATUTE

Sec. 2. Section 36-2982, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2982. Children's health insurance program; administration; nonentitlement; enrollment eligibility

A. **The children's health insurance program is established for children who are eligible pursuant to section 36-2981, paragraph 6. The administration shall administer the program. All covered services shall be provided by health plans that have contracts with the administration pursuant to section 36-2906, by a qualifying plan or by either tribal facilities or the Indian health service for Native Americans who are eligible for the program and who elect to receive services through the Indian health service or a tribal facility.**

B. **This article does not create a legal entitlement for any applicant or member who is eligible for the program. ~~Total enrollment is limited based on the annual appropriations made by the legislature and the enrollment cap prescribed in section 36-2985.~~**

C. **The director shall take all steps necessary to implement the administrative structure for the program and to begin delivering services to persons within sixty days after approval of the state plan by the United States department of health and human services.**

D. **The administration shall perform eligibility determinations for persons applying for eligibility and annual redeterminations for continued eligibility pursuant to this article.**

E. **The administration shall adopt rules for the collection of copayments from members whose income does not exceed one hundred fifty per cent of the federal poverty level and for the collection of copayments and premiums from members whose income exceeds one hundred fifty per cent of the federal poverty level. The director shall adopt rules for disenrolling a member if the member does not pay the premium required pursuant to this section. The director shall adopt rules to prescribe the circumstances under which the administration shall grant a hardship exemption to the disenrollment requirements of this subsection for a member who is no longer able to pay the premium.**

F. **Before enrollment, a member, or if the member is a minor, that member's parent or legal guardian, shall select an available health plan in the member's geographic service area or a qualifying health plan offered in the county, and may select a primary care physician or primary care practitioner from among the available physicians and practitioners participating with the contractor in which the member is enrolled. The contractors shall only reimburse costs of services or related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled, except for emergency services that shall be reimbursed pursuant to section 36-2987. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors.**

G. **Eligibility for the program is creditable coverage as defined in section 20-1379.**

H. ~~**H. On application for eligibility for the program, the member, or if the member is a minor, the member's parent or guardian, shall receive an application for and a program description of the premium sharing program.**~~

I. ~~**I.**~~ **H. Notwithstanding section 36-2983, the administration may purchase for a member employer sponsored group health insurance with state and federal monies available pursuant to this article, subject to any restrictions imposed by the ~~federal health care financing administration~~ CENTERS FOR MEDICARE AND MEDICAID SERVICES. This subsection does not apply to members who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency in this state.**

END_STATUTE

Sec. 3. Repeal

Section 36-2985, Arizona Revised Statutes, is repealed.

Sec. 4. Section 36-2986, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2986. Administration; powers and duties of director

A. **The director has full operational authority to adopt rules or to use the appropriate rules adopted for article 1 of this chapter to implement this article, including any of the following:**

1. **Contract administration and oversight of contractors.**
2. **Development of a complete system of accounts and controls for the program including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably including inpatient behavioral health services provided in a hospital.**
3. **Establishment of peer review and utilization review functions for all contractors.**
4. **Development and management of a contractor payment system.**
5. **Establishment and management of a comprehensive system for assuring quality of care.**
6. **Establishment and management of a system to prevent fraud by members, contractors and health care providers.**

7. **Development of an outreach program. The administration shall coordinate with public and private entities to provide outreach services for children under this article. Priority shall be given to those families who are moving off welfare. Outreach activities shall include strategies to inform communities, including tribal communities, about the program, ensure a wide distribution of applications and provide training for other entities to assist with the application process.**
8. **Coordination of benefits provided under this article for any member. The director may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The director may require members to assign to the administration rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies. The state has a right of subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this paragraph are controlling over the provisions of any insurance policy that provides benefits to a member if the policy is inconsistent with this paragraph.**
9. **Development and management of an eligibility, enrollment and redetermination system, including a process for quality control.**
10. **Establishment and maintenance of an encounter claims system that ensures that ninety per cent of the clean claims are paid within thirty days after receipt and ninety-nine per cent of the remaining clean claims are paid within ninety days after receipt by the administration or contractor unless an alternative payment schedule is agreed to by the contractor and the provider. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.**
11. **Establishment of standards for the coordination of medical care and member transfers.**
12. **Requiring contractors to submit encounter data in a form specified by the director.**
13. **Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection L.**

B. **Notwithstanding any other law, if Congress amends title XXI of the social security act and the administration is required to make conforming changes to rules adopted pursuant to this article, the administration shall request a hearing with the joint health committee of reference for review of the proposed rule changes.**

C. **The director may subcontract distinct administrative functions to one or more persons who may be contractors within the system.**

D. **The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administration and that these records be maintained by the contractor for five years. The director shall also require that these records are available by a contractor on request of the secretary of the United States department of health and human services.**

E. **Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which this information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall be designed to provide for the exchange of necessary information for the purposes of eligibility determination under this article. Notwithstanding any other law, a member's medical record shall be released without the member's consent in situations of suspected cases of fraud or abuse relating to the system to an officer of this state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.**

F. **The director shall provide for the transition of members between contractors and noncontracting providers and the transfer of members who have been determined eligible from hospitals that do not have contracts to care for these persons.**

G. **To the extent that services are furnished pursuant to this article, a contractor is not subject to title 20 unless the contractor is a qualifying plan and has elected to provide services pursuant to this article.**

H. **As a condition of a contract, the director shall require contract terms that are necessary to ensure adequate performance by the contractor. Contract provisions required by the director include the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors who have posted other security, equal to or greater than that required by the administration, with a state agency for the performance of health service contracts if monies would be available from that security for the system on default by the contractor.**

I. **The director shall establish solvency requirements in contract that may include withholding or forfeiture of payments to be made to a contractor by the administration for the failure of the contractor to comply with a provision of the contract with the administration. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and to accomplish the orderly transition of members to other contractors or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor providing an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.**

J. **For the sole purpose of matters concerning and directly related to this article, the administration is exempt from section 41-192.**

K. **The director may withhold payments to a noncontracting provider if the noncontracting provider does not comply with this article or adopted rules that relate to the specific services rendered and billed to the administration.**

L. **The director shall:**

1. **Prescribe uniform forms to be used by all contractors and furnish uniform forms and procedures, including methods of identification of members. The rules shall include requirements that an applicant personally complete or assist in the completion of eligibility application forms, except in situations in which the person is disabled.**
2. **By rule, establish a grievance and appeal procedure that conforms with the process and the time frames specified in article 1 of this chapter. ~~If the program is suspended or terminated pursuant to section 36-2985, an applicant or member is not entitled to contest the denial, suspension or termination of eligibility for the program.~~**
3. **Apply for and accept federal monies available under title XXI of the social security act. Available state monies appropriated to the administration for the operation of the program shall be used as matching monies to secure federal monies pursuant to this subsection.**

M. **The administration is entitled to all rights provided to the administration for liens and release of claims as specified in sections 36-2915 and 36-2916 and shall coordinate benefits pursuant to section 36-2903, subsection F and be a payor of last resort for persons who are eligible pursuant to this article.**

N. **The director shall follow the same procedures for review committees, immunity and confidentiality that are prescribed in article 1 of this chapter.**

END_STATUTE

Sec. 5. Repeal

Section 42-5017, Arizona Revised Statutes, is repealed.

Sec. 6. Services to children; waiver

On or before October 1, 2011, the Arizona health care cost containment system administration shall request a waiver from the centers for medicare and medicaid services to allow services to all children who are eligible pursuant to section 36-2981, Arizona Revised Statutes.

Sec. 7. Appropriation; services to eligible children; exemption

A. **The sum of $13,600,000 is appropriated from the state general fund in fiscal year 2011-2012 to the Arizona health care cost containment system administration for services to children who are eligible pursuant to section 36-2981, Arizona Revised Statutes.**

B. **The appropriation made in subsection A of this section is exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.**

Sec. 8. Requirements for enactment; two-thirds vote

Pursuant to article IX, section 22, Constitution of Arizona, this act is effective only on the affirmative vote of at least two-thirds of the members of each house of the legislature and is effective immediately on the signature of the governor or, if the governor vetoes this act, on the subsequent affirmative vote of at least three-fourths of the members of each house of the legislature.

REFERENCE TITLE: developmentally disabled; residential programs; costs

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2097

Introduced by: Representative Heinz

AN ACT

AMENDING SECTION 36-562, ARIZONA REVISED STATUTES; RELATING TO DEVELOPMENTAL DISABILITIES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 36-562, Arizona Revised Statutes, is amended to read:
START_STATUTE36-562. Schedule of financial contribution; review of payment order

A. **Money for the support of a person with a developmental disability in a residential program operated or supported by the department, except for children placed in special foster homes as described in section 36-558.01, pursuant to sections 8-242, 8-514.01 and 8-845, shall be**

paid to the department, and by it deposited, pursuant to sections 35-146 and 35-147, and shall continue to be paid unless the person is terminated from such residential program.

B. **The financial contribution by the parent of a minor with a developmental disability shall terminate on the eighteenth birthday of such person. The financial contribution by parents on behalf of two or more persons with developmental disabilities receiving developmental disabilities programs or services shall not exceed the maximum amount such parents would be required to pay if only one of such children were receiving the programs or services.**

C. **The department ~~shall~~ by rule SHALL prescribe a fee schedule for developmental disability residential programs provided directly or indirectly by the department. The amount of annual liability of a person with a developmental disability or parent for residential programs and services provided shall be based on the percentage of gross income of the person with a developmental disability or parent, as defined by section 61 of the United States internal revenue code, except that part of the gross income of a self-employed person that results from the operation of ~~his~~ THAT PERSON'S business shall be adjusted by the deductions allowed in the internal revenue code relating to ~~such~~ THAT income in computing adjusted gross income.**

D. **For a person with a developmental disability or a parent of a minor with a developmental disability with an estate, trust or annuity, the amount of annual liability for residential programs and services shall be based on the actual cost of services until the individual meets the financial eligibility requirements for federal social security supplemental income benefits or the financial eligibility requirements for the Arizona long-term care system. In billing a trust, the department is not limited to trust income, but shall also bill the trust corpus.**

E. **The director shall review ~~his~~ THE DIRECTOR'S order for payment for residential care and services at least annually, and shall require the responsible person to update the financial information provided annually or at any time on request by the county board of supervisors or by the parent, guardian, or other person making such payments. Section 36-563 applies to any order or change in order for payment.**

F. **The responsible person shall furnish current financial information to the director and to the appropriate county board of supervisors at the times and on the forms and in the manner prescribed by the director, provided that such information shall be held by the director and the county board of supervisors to be strictly confidential, and it shall not be divulged except in the instance where it is necessary in connection with legal action.**

G. **A financial contribution, which shall not exceed the actual cost of the programs and services provided, may be required from the client or the parent, spouse or estate of a person with a developmental disability for the cost of any nonresidential developmental disability program or service operated by or supported by the department. The department ~~shall~~ by rule SHALL adopt a fee schedule for financial contributions. The amount of liability of a client or the parent, spouse or estate of a client for nonresidential services and programs or any combination of residential and nonresidential services and programs shall not exceed the amount of the fee prescribed for residential services in subsection C of this section. Counties are not required to contribute to the cost of nonresidential services or programs provided to clients.**

H. **The amount payable by the person with a developmental disability or the person's parent or estate for residential services shall be fixed by the director in accordance with the fee schedule prescribed in this section.**

I. **Money paid by a client, parent or guardian shall be paid to the director and deposited, pursuant to sections 35-146 and 35-147, in the state general fund.**

J. **The department shall provide monthly, or more frequent, billings, as required, to all persons responsible for paying for developmentally disabled residential or nonresidential services and programs provided directly or indirectly by the department. The department**

shall require all purchase of care providers to provide current lists of all persons receiving residential or nonresidential services and programs in facilities operated by such providers. The department shall forward reports of delinquent billings for residential and nonresidential services and programs provided by the department or by contractors to the attorney general for collection.

K. **The department shall notify each client and the parent or guardian of such client for whom it has determined that contributions are required for the cost of residential or nonresidential services and programs that it reserves the right to terminate developmental disability residential or nonresidential services and programs to a client for nonpayment of fees required to be paid pursuant to this section.**

L. **Any person affected by an order of the director for payment of costs of care may contest such order and request an administrative hearing pursuant to section 36-563. Any person liable for the costs of care of a client may appeal to the director, pursuant to section 36-563, for a reduction in the amount of payment for such costs of care on the basis of hardship.**

M. **Notwithstanding subsections C and H of this section, the department may require clients who are receiving residential programs and who receive income or benefits to contribute to the cost of their support and maintenance, subject to the provisions of federal laws and regulations. Such contributions ~~shall~~ ARE not ~~be~~ subject to subsections A and I of this section. The department shall adopt rules that determine the amount and means of payment of such contributions, except that ~~in no event shall~~ the combined contribution made on behalf of a client by a client or the client's parent or estate SHALL NOT exceed the actual cost of the residential programs provided. A minimum of ~~twelve~~ THIRTY per cent of the client's income or benefits shall be retained for the client's personal use.**

END_STATUTE

HOUSE OF REPRESENTATIVES
HB 2103
homemade food products; regulation; exception
Sponsor: Representative Kavanagh

X	Committee on Commerce
	Caucus and COW
	House Engrossed

OVERVIEW

HB 2103 permits food and drink that is not potentially hazardous to be made for commercial purposes if there is full disclosure of all pertinent information on the label.

HISTORY

The Director of the Arizona Department of Health Services (Director) must exercise general supervision over all matters concerning sanitation and health matter in Arizona. The Director is charged with adopting administrative rules (Rules) that prescribe the minimum safety standards for food and drink sold in the retail market. To protect the public, the standards must include the sanitary conditions for the facility in which the product is produced, processed, stored, served or transported. This includes warehouses, restaurants, premises, transport trucks or other vehicles used in the food industry. Additionally, the Rules must outline inspection and licensing procedures for the premises and vehicles. There are several exemptions to these requirements, including such things as charitable organization events; work place social activities (pot-lucks); cooking schools in an owner-occupied home; and occasional non-commercial home-cooked food that is not *potentially hazardous*. (A.R.S. § 36-136)

Title 36, Section 136, Subsection D, Arizona Revised Statutes, authorizes the Director to delegate certain functions, powers and duties to the local or county health departments, or county environmental departments. This delegation of authority includes issues relating to food and drink processing.

In addition to the statutory requirements imposed by the State of Arizona, the county health departments have adopted pertinent health codes, permit requirements (depending on the type of business or operation), and facilities must meet county food preparation approval standards.

PROVISIONS

- Permits foods that are not potentially hazardous to be home-prepared in private kitchens for commercial purposes if there is proper disclosure.
- Stipulates the label must clearly state the address and contact information of the maker, list the contents and state the product was not government-inspected.

HOUSE OF REPRESENTATIVES
HB 2103
homemade food products; regulation; exception
Sponsor: Representative Kavanagh

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PROVISIONS

- Permits foods that are not potentially hazardous to be home-prepared in private kitchens for commercial purposes if there is proper disclosure.
- Stipulates the label must clearly state the address and contact information of the maker, list the contents and state the product was not government-inspected.

AMENDMENTS

- Limits the provisions of the bill specifically to confectionery products individually wrapped.
- Requires any allergens to be included on the label and noted in bold type.
- Includes a copy of the person's food handler's license as required information.

Fiftieth Legislature, First Regular Session
COMMITTEE ON COMMERCE

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2103
(Reference to printed bill)

Page 1, line 5, after "personnel" insert "; definition"
Page 3, line 41, strike "AND" insert "CONFECTIONERY PRODUCT"
Line 42, strike "IT" insert "THE CONFECTIONERY PRODUCT"
Line 43, after "INFORMATION" insert "AND A COPIED IMAGE OF THE MAKER'S FOOD HANDLERS LICENSE"
Line 44, after "CONTENTS" insert "IN BOLD TYPE WITH ANY ALLERGENS CONTAINED IN THE CONFECTIONERY PRODUCT"; after "THE" insert "CONFECTIONERY"

Line 45, after the period insert "FOR THE PURPOSES OF THIS SUBDIVISION, "CONFECTIONERY PRODUCT" MEANS INDIVIDUALLY PACKAGED CANDIES THAT ARE SUGAR-FREE OR CONTAIN SUGAR."
Amend title to conform

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2103

Introduced by: Representative Kavanagh

AN ACT
AMENDING SECTION 36-136, ARIZONA REVISED STATUTES; RELATING TO THE DEPARTMENT OF HEALTH SERVICES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 36-136, Arizona Revised Statutes, is amended to read:

START_STATUTE36-136. Powers and duties of director; compensation of personnel

A. **The director shall:**
1. **Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.**
2. **Perform all duties necessary to carry out the functions and responsibilities of the department.**
3. **Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.**
4. **Administer and enforce the laws relating to health and sanitation and the rules of the department.**
5. **Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of the state.**
6. **Exercise general supervision over all matters relating to sanitation and health throughout the state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of the state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of the state that the director has the duty to administer.**
7. **Prepare sanitary and public health rules.**
8. **Perform other duties prescribed by law.**

B. **If the director has reasonable cause to believe that there exists a violation of any health law or rule of the state, the director may inspect any person or property in transportation through the state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.**
C. **The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.**
D. **The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:**
    1. **The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director.**
    2. **Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to assure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.**
E. **The compensation of all personnel shall be as determined pursuant to section 38-611.**
F. **The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.**
G. **Notwithstanding subsection H, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.**
H. **The director, by rule, shall:**

    1. **Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.**
    2. **Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.**
    3. **Define and prescribe reasonably necessary procedures not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.**

4. **Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to assure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food and drink that is:**
    a) **Served at a noncommercial social event that takes place at a workplace, such as a potluck.**
    b) **Prepared at a cooking school that is conducted in an owner-occupied home.**
    c) **Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.**
    d) **Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.**
    e) **Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on site for immediate consumption.**
    f) **Offered at locations that sell only commercially prepackaged food and drink that is not potentially hazardous and that is displayed in an area of less than ten ~~lineal~~ LINEAR feet.**
    g) **NOT POTENTIALLY HAZARDOUS AND PREPARED IN A KITCHEN OF A PRIVATE HOME FOR COMMERCIAL PURPOSES IF IT IS PACKAGED WITH A LABEL THAT CLEARLY STATES THE ADDRESS OF THE MAKER, INCLUDES CONTACT INFORMATION, LISTS THE CONTENTS AND DISCLOSES THAT THE PRODUCT WAS PREPARED WITHOUT GOVERNMENT INSPECTION.**
    h) **Prescribe reasonably necessary measures to assure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.**
    i) **Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to assure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed,**

stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

5. **Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to assure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.**
6. **Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparation of food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules.**
7. **Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.**
8. **Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.**
9. **Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.**
10. **Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.**

I. **The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or**

county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

J. **The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.**

K. **The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.**

L. **After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.**

M. **Until the department adopts exemptions by rule as required by subsection H, paragraph 4, subdivision (b) of this section, a kitchen in a private home that is used as a cooking school and that prepares and offers food to students is exempt from the rules prescribed in subsection H of this section if all of the following are true:**

1. **Only one cooking school meal per day is prepared and served.**
2. **The meal is served to not more than fifteen cooking school students.**
3. **The students are informed by a statement contained in a published advertisement, mailed brochure and placard posted at the cooking school's registration that the food is prepared in a kitchen that is not regulated and inspected by the department or by a local health authority.**

END_STATUTE

REFERENCE TITLE: insurance; mental health coverage; parity

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2128

Introduced by: Representative Patterson

AN ACT

AMENDING SECTION 20-2322, ARIZONA REVISED STATUTES; RELATING TO ACCOUNTABLE HEALTH PLANS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 20-2322, Arizona Revised Statutes, is amended to read:

START_STATUTE20-2322. Mental health services and benefits; definitions

A. **Beginning on January 1, 1998, any health benefits plan that is offered by an accountable health plan and that provides services or health benefits that include mental health services or mental health benefits shall comply with this section.**

B. **If the health benefits plan does not include an aggregate lifetime limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall not impose any aggregate lifetime limit on mental health services or mental health benefits. If the health benefits plan includes an aggregate lifetime limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall either:**
   1. **Apply the applicable lifetime limit to both the health services or health benefits that are not related to mental health services or mental health benefits and to the mental health services or mental health benefits.**
   2. **Not include an aggregate lifetime limit on mental health services or mental health benefits that is less than the applicable lifetime limit for health services or health benefits that are not related to mental health services or mental health benefits.**

C. **If the health benefits plan does not include an aggregate annual limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall not impose any aggregate annual limit on mental health services or mental health benefits. If the health benefits plan includes an aggregate annual limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall either:**
   1. **Apply the applicable annual limit to both the health services or health benefits that are not related to mental health services or mental health benefits and to the mental health services or mental health benefits.**
   2. **Not include any aggregate annual limit on mental health services or mental health benefits that is less than the applicable annual limit for health services or health benefits that are not related to mental health services or mental health benefits.**

D. ~~**Except as provided in subsections A, B and C, this section does not prevent an accountable health plan that offers a health benefits plan that provides mental health services or mental health benefits from imposing terms and conditions, including cost sharing, limits on the number of visits or days of coverage or requirements relating to medical necessity in relation to the amount, duration or scope of coverage for mental health services or mental health benefits under the health benefits plan.**~~ **AN ACCOUNTABLE HEALTH PLAN THAT OFFERS A HEALTH BENEFITS PLAN THAT PROVIDES MENTAL HEALTH SERVICES OR MENTAL HEALTH BENEFITS SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH SERVICES OR MENTAL HEALTH BENEFITS COVERAGE UNLESS COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON THE HEALTH SERVICES OR HEALTH BENEFITS THAT ARE NOT RELATED TO MENTAL HEALTH SERVICES OR MENTAL HEALTH BENEFITS. Nothing in this section requires an accountable health plan to:**
   1. **Offer a health benefits plan that provides mental health services or mental health benefits.**

2. **Comply with this section in connection with any health benefits plan offered to a small employer.**
3. **Comply with this section if that compliance under the health benefits plan offered by the accountable health plan would result in an increase in the cost to the health benefits plan of at least ~~one~~ TWO per cent IN THE FIRST YEAR AND AT LEAST ONE PER CENT IN ANY SUBSEQUENT YEAR.**

E. **The requirements of this section apply separately to each health benefits plan offered by an accountable health plan and shall be consistent with title VII of the health insurance portability and accountability act of 1996 (P.L. 104-204; 110 Stat. 2944) and 45 Code of Federal Regulations part 146.**

~~**F. Mental health services or mental health benefits do not include benefits for the treatment of substance abuse or chemical dependency.**~~

~~**G.**~~ **F. For the purposes of this section:**

1. **"Aggregate annual limit" means a dollar limitation on the total amount that may be paid in a twelve month period for benefits or services under a health benefits plan for an individual who is covered under a health benefits plan.**
2. **"Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits or services under a health benefits plan for an individual who is covered under a health benefits plan.**
3. **"FINANCIAL REQUIREMENTS" INCLUDE:**
   a) **DEDUCTIBLES.**
   b) **COINSURANCE.**
   c) **COPAYMENTS.**
   d) **OTHER COST SHARING REQUIREMENTS.**
4. **"MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES, AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE HEALTH BENEFITS PLAN, FOR ALL CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL ILLNESS OR SUBSTANCE RELATED DISORDERS THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE HEALTH BENEFITS PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.**
5. **"TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE HEALTH BENEFITS PLAN.**

END_STATUTE

REFERENCE TITLE: guardians of incapacitated persons

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2402

Introduced by: Representative Vogt

AN ACT

AMENDING TITLE 14, CHAPTER 5, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 14-5304.01; AMENDING SECTIONS 14-5312.01, 36-509 AND 36-540, ARIZONA REVISED STATUTES; RELATING TO GUARDIANS OF INCAPACITATED PERSONS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Title 14, chapter 5, article 3, Arizona Revised Statutes, is amended by adding section 14-5304.01, to read:

START_STATUTE14-5304.01. Effect of appointment of guardian on privilege to operate a motor vehicle

A. **ON THE APPOINTMENT OF A GUARDIAN, THE COURT MAY DETERMINE THAT THE WARD'S PRIVILEGE TO OBTAIN OR RETAIN A DRIVER LICENSE SHOULD BE SUSPENDED AND ISSUE AN ORDER SUSPENDING THE PRIVILEGE.**

B. **IF THE COURT IS PRESENTED WITH SUFFICIENT MEDICAL OR OTHER EVIDENCE TO ESTABLISH THAT THE WARD'S INCAPACITY DOES NOT PREVENT THE WARD FROM SAFELY OPERATING A MOTOR VEHICLE, IT MAY DECLINE TO SUSPEND THE WARD'S PRIVILEGE TO OBTAIN OR RETAIN A DRIVER LICENSE AND ISSUE AN ORDER ALLOWING THE WARD TO OBTAIN OR RETAIN A DRIVER LICENSE.**

C. **THE FINDING OF INTERIM INCAPACITY PURSUANT TO SECTION 14-5310 DOES NOT CAUSE THE SUSPENSION OF THE WARD'S PRIVILEGE TO OBTAIN OR RETAIN A DRIVER LICENSE OR TO OPERATE A MOTOR VEHICLE PURSUANT TO SECTION 28-3153 UNLESS THE COURT ALSO FINDS THAT THE INTERIM INCAPACITY AFFECTS THE WARD'S ABILITY TO SAFELY OPERATE A MOTOR VEHICLE AND THAT THE PRIVILEGE SHOULD BE IMMEDIATELY SUSPENDED. IN LIEU OF ORDERING THE WARD'S DRIVER LICENSE SUSPENDED, THE COURT MAY ORDER THE WARD NOT TO DRIVE A MOTOR VEHICLE UNTIL THE WARD PRESENTS SUFFICIENT MEDICAL OR OTHER EVIDENCE TO ESTABLISH THAT THE WARD'S INTERIM INCAPACITY DOES NOT AFFECT THE WARD'S ABILITY TO SAFELY OPERATE A MOTOR VEHICLE. THE WARD MAY PRESENT THE MEDICAL OR OTHER EVIDENCE BY MOTION TO THE COURT. THE COURT MAY RULE ON THE MOTION WITHOUT HEARING IF THERE ARE NO OBJECTIONS TO THE MOTION.**

D. **A WARD WHOSE PRIVILEGE TO OBTAIN OR RETAIN A DRIVER LICENSE HAS BEEN SUSPENDED OR REVOKED BY COURT ORDER MAY FILE A REQUEST TO TERMINATE THE SUSPENSION OR REVOCATION AND REINSTATE THE PRIVILEGE. IN REACHING ITS DECISION THE COURT SHALL CONSIDER MEDICAL EVIDENCE THAT THE WARD'S INCAPACITY DOES NOT PREVENT THE WARD FROM SAFELY OPERATING A MOTOR VEHICLE AND MAY CONSIDER OTHER EVIDENCE, INCLUDING A CERTIFICATE OF GRADUATION FROM AN ACCREDITED DRIVING SCHOOL WITH A RECOMMENDATION THAT THE WARD SHOULD BE EXTENDED DRIVING PRIVILEGES. IF THE COURT GRANTS THE ORDER TERMINATING THE SUSPENSION OR REVOCATION AND REINSTATING THE PRIVILEGE,**

THE WARD MAY APPLY TO THE DEPARTMENT OF TRANSPORTATION FOR THE ISSUANCE OR REINSTATEMENT OF A DRIVER LICENSE AND MUST COMPLY WITH ALL APPLICABLE DEPARTMENT RULES.

E. **AN ORDER TERMINATING A TEMPORARY OR PERMANENT GUARDIANSHIP IS AN ORDER TERMINATING ANY INCAPACITY PREVIOUSLY ADJUDICATED AND VACATES ANY PREVIOUS ORDERS SUSPENDING OR REVOKING THE PERSON'S PRIVILEGE TO OBTAIN OR RETAIN A DRIVER LICENSE. THE PERSON MAY APPLY TO THE DEPARTMENT OF TRANSPORTATION FOR THE ISSUANCE OR REINSTATEMENT OF A DRIVER LICENSE AND MUST COMPLY WITH ALL APPLICABLE DEPARTMENT RULES.**

END_STATUTE

Sec. 2. Section 14-5312.01, Arizona Revised Statutes, is amended to read:

START_STATUTE14-5312.01. Inpatient treatment; rights and duties of ward and guardian

A. **Except as provided in subsection B of this section, a guardian of an incapacitated person may consent to psychiatric and psychological care and treatment, including the administration of psychotropic medications, if the care and treatment take place outside a level one behavioral health facility licensed by the department of health services.**

B. **On clear and convincing evidence that the ward is incapacitated as a result of a mental disorder as defined in section 36-501, and is ~~currently~~ LIKELY TO BE in need of inpatient mental health care and treatment WITHIN THE PERIOD OF THE AUTHORITY GRANTED PURSUANT TO THIS SECTION, the court may authorize a guardian appointed pursuant to this title to give consent for the ward to receive inpatient mental health care and treatment, including placement in a level one behavioral health facility licensed by the department of health services and medical, psychiatric and psychological treatment associated with that placement. The evidence shall be supported by the opinion of a mental health expert who is either a physician licensed pursuant to title 32, chapter 13 or 17 and who is a specialist in psychiatry or a psychologist who is licensed pursuant to title 32, chapter 19.1.**

C. **In making its decision to grant authority to a guardian pursuant to subsection B of this section, the court shall consider the cause of the ward's disability and the ward's foreseeable clinical needs. The court shall limit the guardian's authority to what is reasonably necessary to obtain the care required for the ward in the least restrictive treatment alternative. The court may limit the duration of the guardian's authority to consent to inpatient mental health care and treatment and include other orders the court determines necessary to protect the ward's best interests.**

D. **Within forty-eight hours after placement of the ward pursuant to this section, the guardian shall give notice of this action to the ward's attorney. When the attorney receives this notice the attorney shall assess the appropriateness of the placement pursuant to section 36-537, subsection B and section 36-546, subsection H. If requested by the attorney, the court shall hold a hearing on the appropriateness of the placement within three days after receiving that request.**

E. **The behavioral health treatment facility shall assess the appropriateness of the ward's placement every thirty days and shall provide a copy of the assessment report to the ward's attorney. The ward's attorney may attend the ward's evaluation, staffing, treatment team and case management meetings.**

F. **When the ward is admitted to a level one behavioral health treatment facility pursuant to this section, the guardian shall provide the facility with the name, address and telephone number of the ward's attorney. The facility shall include this information in the ward's treatment record.**

G. **Within twenty-four hours after the facility receives any writing in which the ward requests release from the facility, any change in placement or a change in the type or duration of treatment, the facility shall forward this information to the ward's attorney.**

H. **All health care providers, treatment facilities and regional behavioral health authorities shall allow the ward's attorney access to all of the ward's medical, psychiatric, psychological and other treatment records.**

I. **The ward's guardian shall place the ward in a least restrictive treatment alternative within ten days after the guardian is notified by the medical director of the inpatient facility that the ward no longer needs inpatient care. The ward, a representative of the inpatient treatment facility, the ward's attorney, the ward's physician or any other interested person may petition the court to order the facility to discharge the ward to a least restrictive treatment alternative if the guardian does not act promptly to do so.**

J. **If the ward is in a behavioral health treatment facility at the time of the initial hearing on the petition for appointment of a guardian, the court investigator and the ward's attorney shall advise the court of the appropriateness of the placement.**

K. **An attorney appointed pursuant to section 14-5303, subsection C remains the attorney of record until the attorney is discharged by the court. The court shall ensure that a ward whose guardian has been granted mental health treatment authority is represented by an attorney at all times the guardian has that authority. Unless the court finds that the ward has insufficient assets to meet the ward's reasonable and necessary care and living expenses, the ward shall pay the attorney's reasonable fees.**

L. **If deemed necessary to adequately assess a request for mental health treatment authority or to review the ward's placement in a behavioral health treatment facility, the court may order an independent evaluation by either a physician who is licensed pursuant to title 32, chapter 13 or 17 and who is a specialist in psychiatry or a psychologist who is licensed pursuant to title 32, chapter 19.1. If the ward has insufficient funds to pay the total cost of this evaluation, the court may deem all or any part of the evaluator's fee to be a county expense after determining the reasonableness of that fee.**

M. **Instead of ordering an independent evaluation pursuant to subsection L of this section, the court may accept a report conducted on behalf of the behavioral health treatment facility if the court finds that the report meets the requirements of an independent evaluation.**

N. **The court may decide that the ward's right to retain or obtain a driver license and any other civil right that may be suspended by operation of law is not affected by the appointment of a guardian.**

O. **If the court grants the guardian the authority to consent to inpatient mental health care and treatment pursuant to this section, the medical director of a level one behavioral health facility licensed by the department of health services may admit the ward at the guardian's request.**

P. **A guardian who is authorized by the court to consent to inpatient mental health care and treatment pursuant to this section shall file with the annual report of the guardian required pursuant to section 14-5315 an evaluation report by a physician or a psychologist who meets the requirements of subsection B of this section. The evaluation report shall indicate if the ward ~~currently needs~~ WILL LIKELY NEED inpatient mental health care and treatment WITHIN THE PERIOD OF THE AUTHORITY GRANTED PURSUANT TO THIS SECTION. If the guardian does not file the evaluation report or if the report indicates that the ward ~~does~~ WILL not LIKELY need inpatient mental health care and treatment, the guardian's authority to consent to this treatment ceases ON THE EXPIRATION OF THE PERIOD SPECIFIED IN THE PRIOR COURT ORDER. If the report ~~indicates that the ward currently needs this~~ SUPPORTS THE CONTINUATION OF THE GUARDIAN'S AUTHORITY TO CONSENT TO INPATIENT treatment, THE COURT MAY ORDER THAT the guardian's authority to consent to this treatment continues. If the report**

supports the continuation of the guardian's authority to consent to this treatment, the ward's attorney shall review the report with the ward. The ward may contest the continuation of the guardian's authority by filing a request for a court hearing within ten business days after the report is filed. The court shall hold this hearing within thirty calendar days after it receives the request. The guardian's authority continues pending the court's ruling on the issue. At the hearing the guardian has the burden of proving by clear and convincing evidence that the ward is ~~currently~~ LIKELY TO BE in need of inpatient mental health care and treatment WITHIN THE PERIOD OF THE AUTHORITY GRANTED PURSUANT TO THIS SECTION.

Q. **The court may discharge an attorney who was appointed pursuant to section 14-5303, subsection C subsequent to the appointment of a guardian if it clearly appears from specific facts presented by affidavit or verified petition that continued representation of the ward is no longer necessary or desirable. The factual basis must include, at a minimum, consideration of the following:**

1. **The nature and history of the ward's illness.**
2. **The ward's history of hospitalization.**
3. **The ward's current and anticipated living arrangements.**
4. **Whether the ward's inpatient treatment is anticipated to be a one-time hospitalization for the purpose of stabilizing the ward's condition and further hospitalizations are not likely to be necessary.**
5. **Whether the ward's current and anticipated living arrangements are the least restrictive alternatives possible.**

END_STATUTE

Sec. 3. Section 36-509, Arizona Revised Statutes, is amended to read:

START_STATUTE36-509. Confidential records

A. **A health care entity must keep records and information contained in records confidential and not as public records, except as provided in this section. Records and information contained in records may only be disclosed to:**

1. **Physicians and providers of health, mental health or social and welfare services involved in caring for, treating or rehabilitating the patient.**
2. **Individuals to whom the patient or the patient's health care decision maker has given authorization to have information disclosed.**
3. **Persons authorized by a court order.**
4. **Persons doing research only if the activity is conducted pursuant to applicable federal or state laws and regulations governing research.**
5. **The state department of corrections in cases in which prisoners confined to the state prison are patients in the state hospital on authorized transfers either by voluntary admission or by order of the court.**
6. **Governmental or law enforcement agencies if necessary to:**
   a) **Secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing evaluation and treatment.**
   b) **Report a crime on the premises.**
   c) **Avert a serious and imminent threat to an individual or the public.**
7. **Persons, including family members, actively participating in the patient's care, treatment or supervision. A health care provider may only release information relating to the patient's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects and short-term and long-term treatment goals. A health care provider may make this release only after the treating professional or that person's designee interviews the patient or the patient's health care decision maker and the patient or the patient's health care decision maker does not**

object, unless federal or state law permits the disclosure. If the patient does not have the opportunity to object to the disclosure because of incapacity or an emergency circumstance and the patient's health care decision maker is not available to object to the release, the health care provider in the exercise of professional judgment may determine if the disclosure is in the best interests of the patient and, if so, may release the information authorized pursuant to this paragraph. A decision to release or withhold information is subject to review pursuant to section 36-517.01. The health care provider must record the name of any person to whom any information is given under this paragraph.

8. **A state agency that licenses health professionals pursuant to title 32, chapter 13, 15, 17, 19.1 or 33 and that requires these records in the course of investigating complaints of professional negligence, incompetence or lack of clinical judgment.**
9. **A state or federal agency that licenses health care providers.**
10. **A governmental agency or a competent professional, as defined in section 36-3701, in order to comply with chapter 37 of this title.**
11. **Human rights committees established pursuant to title 41, chapter 35. Any information released pursuant to this paragraph shall comply with the requirements of section 41-3804 and applicable federal law and shall be released without personally identifiable information unless the personally identifiable information is required for the official purposes of the human rights committee. Case information received by a human rights committee shall be maintained as confidential. For the purposes of this paragraph, "personally identifiable information" includes a person's name, address, date of birth, social security number, tribal enrollment number, telephone or telefacsimile number, driver license number, places of employment, school identification number and military identification number or any other distinguishing characteristic that tends to identify a particular person.**
12. **A patient or the patient's health care decision maker pursuant to section 36-507.**
13. **The department of public safety by the court to comply with the requirements of section 36-540, subsection ~~N~~ O.**
14. **A third party payor or the payor's contractor to obtain reimbursement for health care, mental health care or behavioral health care provided to the patient.**
15. **A private entity that accredits the health care provider and with whom the health care provider has an agreement requiring the agency to protect the confidentiality of patient information.**
16. **The legal representative of a health care entity in possession of the record for the purpose of securing legal advice.**
17. **A person or entity as otherwise required by state or federal law.**
18. **A person or entity as permitted by the federal regulations on alcohol and drug abuse treatment (42 Code of Federal Regulations part 2).**
19. **A person or entity to conduct utilization review, peer review and quality assurance pursuant to section 36-441, 36-445, 36-2402 or 36-2917.**
20. **A person maintaining health statistics for public health purposes as authorized by law.**
21. **A grand jury as directed by subpoena.**

B. **Information and records obtained in the course of evaluation, examination or treatment and submitted in any court proceeding pursuant to this chapter or title 14, chapter 5 are confidential and are not public records unless the hearing requirements of this chapter or title 14, chapter 5 require a different procedure. Information and records that are obtained pursuant to this section and submitted in a court proceeding pursuant to title 14, chapter 5 and that are not clearly identified by the parties as confidential and segregated from nonconfidential information and records are considered public records.**

C. **Notwithstanding subsections A and B of this section, the legal representative of a patient who is the subject of a proceeding conducted pursuant to this chapter and title 14, chapter 5 has access to the patient's information and records in the possession of a health care entity or filed with the court.**

END_STATUTE

Sec. 4. Section 36-540, Arizona Revised Statutes, is amended to read:

START_STATUTE36-540. Court options

A. **If the court finds by clear and convincing evidence that the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment, and is either unwilling or unable to accept voluntary treatment, the court shall order the patient to undergo one of the following:**
   1. **Treatment in a program of outpatient treatment.**
   2. **Treatment in a program consisting of combined inpatient and outpatient treatment.**
   3. **Inpatient treatment in a mental health treatment agency, in a veterans administration hospital pursuant to article 9 of this chapter, in the state hospital or in a private hospital, if the private hospital agrees, subject to the limitations of section 36-541.**

B. **The court shall consider all available and appropriate alternatives for the treatment and care of the patient. The court shall order the least restrictive treatment alternative available.**

C. **The court may order the proposed patient to undergo outpatient or combined inpatient and outpatient treatment pursuant to subsection A, paragraph 1 or 2 of this section if the court:**
   1. **Determines that all of the following apply:**
      a) **The patient does not require continuous inpatient hospitalization.**
      b) **The patient will be more appropriately treated in an outpatient treatment program or in a combined inpatient and outpatient treatment program.**
      c) **The patient will follow a prescribed outpatient treatment plan.**
      d) **The patient will not likely become dangerous or suffer more serious physical harm or serious illness or further deterioration if the patient follows a prescribed outpatient treatment plan.**
   2. **Is presented with and approves a written treatment plan that conforms with the requirements of section 36-540.01, subsection B. If the treatment plan presented to the court pursuant to this subsection provides for supervision of the patient under court order by a mental health agency that is other than the mental health agency that petitioned or requested the county attorney to petition the court for treatment pursuant to section 36-531, the treatment plan must be approved by the medical director of the mental health agency that will supervise the treatment pursuant to subsection E of this section.**

D. **An order to receive treatment pursuant to subsection A, paragraph 1 or 2 of this section shall not exceed three hundred sixty-five days. The period of inpatient treatment under a combined treatment order pursuant to subsection A, paragraph 2 of this section shall not exceed the maximum period allowed for an order for inpatient treatment pursuant to subsection F of this section.**

E. **If the court enters an order for treatment pursuant to subsection A, paragraph 1 or 2 of this section, all of the following apply:**

   1. **The court shall designate the medical director of the mental health treatment agency that will supervise and administer the patient's treatment program.**
   2. **The medical director shall not use the services of any person, agency or organization to supervise a patient's outpatient treatment program unless the person, agency or organization has agreed to provide these services in the individual patient's case and**

unless the department has determined that the person, agency or organization is capable and competent to do so.

3. **The person, agency or organization assigned to supervise an outpatient treatment program or the outpatient portion of a combined treatment program shall be notified at least three days before a referral. The medical director making the referral and the person, agency or organization assigned to supervise the treatment program shall share relevant information about the patient to provide continuity of treatment.**
4. **During any period of outpatient treatment under subsection A, paragraph 2 of this section, if the court, on motion by the medical director of the patient's outpatient mental health treatment facility, determines that the patient is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate and the patient needs inpatient treatment, the court, without a hearing and based on the court record, the patient's medical record, the affidavits and recommendations of the medical director, and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order. The amended order may alter the outpatient treatment plan or order the patient to inpatient treatment pursuant to subsection A, paragraph 3 of this section. The amended order shall not increase the total period of commitment originally ordered by the court or, when added to the period of inpatient treatment provided by the original order and any other amended orders, exceed the maximum period allowed for an order for inpatient treatment pursuant to subsection F of this section. If the patient refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the medical director, to take the patient into protective custody and transport the patient to the agency for inpatient treatment. When reporting to or being returned to a treatment agency for inpatient treatment pursuant to an amended order, the patient shall be informed of the patient's right to judicial review and the patient's right to consult with counsel pursuant to section 36-546.**
5. **During any period of outpatient treatment under subsection A, paragraph 2 of this section, if the medical director of the outpatient treatment facility in charge of the patient's care determines, in concert with the medical director of an inpatient mental health treatment facility who has agreed to accept the patient, that the patient is in need of immediate acute inpatient psychiatric care because of behavior that is dangerous to self or to others, the medical director of the outpatient treatment facility may order a peace officer to apprehend and transport the patient to the inpatient treatment facility pending a court determination on an amended order under paragraph 4 of this subsection. The patient may be detained and treated at the inpatient treatment facility for a period of no more than forty-eight hours, exclusive of weekends and holidays, from the time that the patient is taken to the inpatient treatment facility. The medical director of the outpatient treatment facility shall file the motion for an amended court order requesting inpatient treatment no later than the next working day following the patient being taken to the inpatient treatment facility. Any period of detention within the inpatient treatment facility pending issuance of an amended order shall not increase the total period of commitment originally ordered by the court or, when added to the period of inpatient treatment provided by the original order and any other amended orders, exceed the maximum period allowed for an order for inpatient treatment pursuant to subsection F of this section. If a patient is ordered to undergo inpatient treatment pursuant to an amended order, the medical director of the outpatient treatment facility shall inform the patient of the patient's right to judicial review and to consult with an attorney pursuant to section 36-546.**

F. **The maximum periods of inpatient treatment that the court may order, subject to the limitations of section 36-541, are as follows:**
   1. **Ninety days for a person found to be a danger to self.**
   2. **One hundred eighty days for a person found to be a danger to others.**
   3. **One hundred eighty days for a person found to be persistently or acutely disabled.**
   4. **Three hundred sixty-five days for a person found to be gravely disabled.**

G. **If, on finding that the patient ~~is gravely disabled~~ MEETS THE CRITERIA FOR COURT-ORDERED TREATMENT PURSUANT TO SUBSECTION A OF THIS SECTION, the court also finds that ~~the evidence indicates~~ THERE IS REASONABLE CAUSE TO BELIEVE THAT THE PATIENT IS AN INCAPACITATED PERSON AS DEFINED IN SECTION 14-5101 OR IS A PERSON IN NEED OF PROTECTION PURSUANT TO SECTION 14-5401 AND that the patient is or may be in need of guardianship or conservatorship, or both, the court ~~shall~~ MAY order an investigation concerning the need for a guardian or conservator, or both, and ~~shall~~ MAY appoint a suitable person or agency to conduct the investigation. The appointee may include ~~the mental health treatment agency that is providing inpatient or outpatient treatment, a court appointed visitor~~ A COURT APPOINTED GUARDIAN AD LITEM, AN INVESTIGATOR APPOINTED PURSUANT TO SECTION 14-5308 or the public fiduciary if there is no person willing and qualified to act in that capacity. The court shall give notice of the appointment to the appointee within three days of the appointment. The appointee shall submit the report of the investigation to the court within twenty-one days. The report shall include recommendations as to who should be guardian or who should be conservator, or both, and a report of the findings and reasons for the recommendation. If the investigation and report so indicate, the court shall order the appropriate person to submit a petition to become the guardian or conservator, or both, of the patient.**

~~**H. If, on finding that a patient is gravely disabled, the court also finds that the patient is in need of immediate guardianship for the purpose of protection of the patient or for the purpose of carrying out alternatives to court ordered treatment, the court may appoint as a temporary guardian a suitable person or the public fiduciary, if there is no person qualified and willing to act in that capacity.**~~

H. IN ANY PROCEEDING FOR COURT-ORDERED TREATMENT IN WHICH THE PETITION ALLEGES THAT THE PATIENT IS IN NEED OF A GUARDIAN OR CONSERVATOR AND STATES THE GROUNDS FOR THAT ALLEGATION, THE COURT MAY APPOINT AN EMERGENCY TEMPORARY GUARDIAN OR CONSERVATOR, OR BOTH, FOR A SPECIFIC PURPOSE OR PURPOSES IDENTIFIED IN ITS ORDER AND FOR A SPECIFIC PERIOD OF TIME NOT TO EXCEED THIRTY DAYS IF THE COURT FINDS THAT ALL OF THE FOLLOWING ARE TRUE:
   1. **THE PATIENT MEETS THE CRITERIA FOR COURT-ORDERED TREATMENT PURSUANT TO SUBSECTION A OF THIS SECTION.**
   2. **THERE IS REASONABLE CAUSE TO BELIEVE THAT THE PATIENT IS AN INCAPACITATED PERSON AS DEFINED IN SECTION 14-5101 OR IS IN NEED OF PROTECTION PURSUANT TO SECTION 14-5401, PARAGRAPH 2.**
   3. **THE PATIENT DOES NOT HAVE A GUARDIAN OR CONSERVATOR AND THE WELFARE OF THE PATIENT REQUIRES IMMEDIATE ACTION TO PROTECT THE PATIENT OR THE WARD'S PROPERTY.**
   4. **THE CONDITIONS PRESCRIBED PURSUANT TO SECTION 14-5310, SUBSECTION B OR SECTION 14-5401.01, SUBSECTION B HAVE BEEN MET.**

I. THE COURT MAY APPOINT AS A TEMPORARY GUARDIAN OR CONSERVATOR PURSUANT TO SUBSECTION H OF THIS SECTION A SUITABLE PERSON OR THE PUBLIC FIDUCIARY IF THERE IS NO PERSON QUALIFIED AND WILLING TO ACT

IN THAT CAPACITY. THE COURT SHALL ISSUE AN ORDER FOR AN INVESTIGATION AS PRESCRIBED PURSUANT TO SUBSECTION G OF THIS SECTION AND, UNLESS THE PATIENT IS REPRESENTED BY INDEPENDENT COUNSEL, THE COURT SHALL APPOINT AN ATTORNEY TO REPRESENT THE PATIENT IN FURTHER PROCEEDINGS REGARDING THE APPOINTMENT OF A GUARDIAN OR CONSERVATOR. THE COURT SHALL SCHEDULE A FURTHER HEARING WITHIN FOURTEEN DAYS ON THE APPROPRIATE COURT CALENDAR OF A COURT THAT HAS AUTHORITY OVER GUARDIANSHIP OR CONSERVATORSHIP MATTERS PURSUANT TO THIS TITLE TO CONSIDER THE CONTINUED NEED FOR AN EMERGENCY TEMPORARY GUARDIAN OR CONSERVATOR AND THE APPROPRIATENESS OF THE TEMPORARY GUARDIAN OR CONSERVATOR APPOINTED, AND SHALL ORDER THE APPOINTED GUARDIAN OR CONSERVATOR TO GIVE NOTICE TO PERSONS ENTITLED TO NOTICE PURSUANT TO SECTION 14-5309, SUBSECTION A OR SECTION 14-5405, SUBSECTION A. THE COURT SHALL AUTHORIZE CERTIFIED LETTERS OF TEMPORARY EMERGENCY GUARDIANSHIP OR CONSERVATORSHIP TO BE ISSUED ON PRESENTATION OF A COPY OF THE COURT'S ORDER. IF A TEMPORARY EMERGENCY CONSERVATOR OTHER THAN THE PUBLIC FIDUCIARY IS APPOINTED PURSUANT TO THIS SUBSECTION, THE COURT SHALL ORDER THAT THE USE OF THE MONEY AND PROPERTY OF THE PATIENT BY THE CONSERVATOR IS RESTRICTED AND NOT TO BE SOLD, USED, TRANSFERRED OR ENCUMBERED, EXCEPT THAT THE COURT MAY AUTHORIZE THE CONSERVATOR TO USE MONEY OR PROPERTY OF THE PATIENT SPECIFICALLY IDENTIFIED AS NEEDED TO PAY AN EXPENSE TO PROVIDE FOR THE CARE, TREATMENT OR WELFARE OF THE PATIENT PENDING FURTHER HEARING. THIS SUBSECTION AND SUBSECTION H OF THIS SECTION DO NOT:

1. **PREVENT THE EVALUATION OR TREATMENT AGENCY FROM SEEKING GUARDIANSHIP AND CONSERVATORSHIP IN ANY OTHER MANNER ALLOWED BY LAW AT ANY TIME DURING THE PERIOD OF COURT-ORDERED EVALUATION AND TREATMENT.**
2. **RELIEVE THE EVALUATION OR TREATMENT AGENCY FROM ITS OBLIGATIONS CONCERNING THE SUSPECTED ABUSE OF A VULNERABLE ADULT PURSUANT TO TITLE 46, CHAPTER 4.**

~~I.~~ **J. If, on finding that a patient ~~is gravely disabled~~ MEETS THE CRITERIA FOR COURT-ORDERED TREATMENT PURSUANT TO SUBSECTION A OF THIS SECTION, the court also learns that the patient has a guardian appointed under title 14, the court with notice may impose on the existing guardian additional duties pursuant to section 14-5312.01. IF THE COURT IMPOSES ADDITIONAL DUTIES ON AN EXISTING GUARDIAN AS PRESCRIBED IN THIS SUBSECTION, THE COURT MAY DETERMINE THAT THE PATIENT NEEDS TO CONTINUE TREATMENT UNDER A COURT ORDER FOR TREATMENT AND MAY ISSUE THE ORDER OR DETERMINE THAT THE PATIENT'S NEEDS CAN BE ADEQUATELY MET BY THE GUARDIAN WITH THE ADDITIONAL DUTIES PURSUANT TO SECTION 14-5312.01 AND DECLINE TO ISSUE THE COURT ORDER FOR TREATMENT. IF AT ANY TIME AFTER THE ISSUANCE OF A COURT ORDER FOR TREATMENT THE COURT FINDS THAT THE PATIENT'S NEEDS CAN BE ADEQUATELY MET BY THE GUARDIAN WITH THE ADDITIONAL DUTIES PURSUANT TO SECTION 14-5312.01 AND THAT A COURT ORDER FOR TREATMENT IS NO LONGER NECESSARY TO ASSURE COMPLIANCE WITH NECESSARY TREATMENT, THE COURT MAY TERMINATE THE COURT ORDER FOR TREATMENT. IF THERE IS A COURT**

ORDER FOR TREATMENT AND A GUARDIANSHIP WITH ADDITIONAL MENTAL HEALTH AUTHORITY PURSUANT TO SECTION 14-5312.01 EXISTING AT THE SAME TIME, THE TREATMENT AND PLACEMENT DECISIONS MADE BY THE TREATMENT AGENCY ASSIGNED BY THE COURT TO SUPERVISE AND ADMINISTER THE PATIENT'S TREATMENT PROGRAM PURSUANT TO THE COURT ORDER FOR TREATMENT ARE CONTROLLING UNLESS THE COURT ORDERS OTHERWISE. A GUARDIAN WITH ADDITIONAL MENTAL HEALTH AUTHORITY PURSUANT TO SECTION 14-5312.01 MAY REQUEST THE COURT TO REVIEW TREATMENT OR PLACEMENT DECISIONS MADE ON BEHALF OF THE GUARDIAN'S WARD BY THE TREATMENT AGENCY.

~~J.~~ **K. The court shall file a report as part of the court record on its findings of alternatives for treatment.**

~~K.~~ **L. Treatment shall not include psychosurgery, lobotomy or any other brain surgery without specific informed consent of the patient or the patient's legal guardian and an order of the superior court in the county in which the treatment is proposed, approving with specificity the use of the treatment.**

~~L.~~ **M. The medical director or any person, agency or organization used by the medical director to supervise the terms of an outpatient treatment plan shall not be held civilly liable for any acts committed by a patient while on outpatient treatment if the medical director, person, agency or organization has in good faith followed the requirements of this section.**

~~M.~~ **N. A peace officer who in good faith apprehends and transports a patient to an inpatient treatment facility on the order of the medical director of the outpatient treatment facility pursuant to subsection E, paragraph 5 of this section ~~shall~~ IS not ~~be~~ subject to civil liability.**

~~N.~~ **O. If a person has been found, as a result of a mental disorder, to constitute a danger to self or others or to be persistently or acutely disabled or gravely disabled and the court enters an order for treatment pursuant to subsection A of this section, the court shall grant access to the person's name, date of birth, social security number and date of commitment to the department of public safety to comply with the requirements of title 13, chapter 31 and title 32, chapter 26. END_STATUTE**

Fiftieth Legislature, First Regular Session
JUD
H.B. 2402

PROPOSED
HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2402
(Reference to printed bill)

Page 11, line 42, after the period strike remainder of line
Strike lines 43 through 45
Amend title to conform

JANSON T. VOGT

HOUSE OF REPRESENTATIVES
HB 2402
guardians of incapacitated persons
Sponsors: Representative Vogt

X	Committee on Judiciary
	Caucus and COW
	House Engrossed

OVERVIEW

HB 2402 makes several changes to the statutes governing incapacitated persons including the establishment of court procedures for determining whether an incapacitated individual's privilege to drive should be suspended or retained; broadens the scope of powers for guardians; and broadens the options that the court may exercise in an involuntary commitment proceeding.

HISTORY

Pursuant to Arizona Revised Statutes (A.R.S.) the Department of Motor Vehicles is prohibited from issuing a driver's license "to a person who has been adjudged to be incapacitated and who has not obtained a court order that allows the person to drive or a termination of the incapacity as provided by law." (A.R.S. § 28-3153). Under current law, the statutes are silent with regard to the court procedures for determining whether an incapacitated individual's privilege to drive should be suspended or retained.

A.R.S. Title 14, Chapter 5 covers the protections of persons under disability and their property. Within that Chapter, Article 3 governs how guardianship is established. A.R.S. § 14-5312.01 establishes that upon clear and convincing evidence that the ward is incapacitated as a result of a mental disorder and is currently in need of inpatient mental health care and treatment, the court may authorize a guardian to give consent for the ward to receive inpatient mental health care and treatment. That section also requires the authorizing guardian to file an annual evaluation report by a physician or psychologist. Under current law, the evaluation report is required to indicate if the ward currently needs inpatient mental health care and treatment.

A.R.S. Title 36, Chapter 5 covers mental health services. Within that Chapter, Article 4 and Article 5 govern how a person may be evaluated for and required to receive court ordered treatment. A.R.S. § 36-540 sets forth options a court may exercise in an involuntary commitment proceeding after finding a patient is in need of treatment. Under current law, a patient can be ordered to undergo treatment on four different grounds- when the patient suffers grave disability, when the patient is a danger to self, when the patient is a danger to others or when the patient is persistently and acutely disabled. Currently, a court is only allowed to order an investigation of the patient's need for guardianship or conservatorship in cases where the order for treatment is sought on grounds of grave disability.

Additionally, A.R.S. § 36-540 currently permits the court to appoint an immediate temporary guardian to protect a person only for a person found to be in need of treatment on the grounds of grave disability. The law does not permit the court to appoint an immediate temporary conservator to protect the person's property.

Finally, A.R.S. § 36-540 currently allows the court to impose on an existing guardian the authority to admit the ward to a level one behavioral health facility for inpatient treatment (commonly referred to as a Mental Health Guardianship).

PROVISIONS

Procedures for Reinstating Privilege to Operate a Motor Vehicle

- Permits the court, on the appointment of a guardian, to determine whether the ward's driver's license is to be suspended.

- Allows the court to decline to suspend the ward's privilege to obtain or retain a driver's license if the court is presented with sufficient medical or other evidence to establish that the ward's incapacity does not prevent the ward's ability to safely operate a motor vehicle.
- States that unless the court finds a ward's ability to drive safely is affected by a finding of interim incapacity and that that the driver's license should be suspended, then a finding of interim incapacity will not cause the ward's driving privilege to be suspended.
- Permits the court, in lieu of ordering the ward's driver license suspended, to order the ward not to drive a motor vehicle until the ward presents sufficient evidence to establish that the ward's interim incapacity does not affect their ability to safely operate a motor vehicle.
- Allows the ward to present the medical or other evidence by motion to the court.
- Authorizes the court to rule on the motion without a hearing if there are no objections to the motion.
- Permits a ward, whose privilege to obtain or retain a driver's license has been suspended by a court order, to file a request to terminate the suspension or revocation and reinstate the privilege.
- Requires the court, in reaching its decision, to consider medical evidence that the ward's incapacity does not prevent the ward from safely operating a motor vehicle.
- Permits the court to, in reaching its decision, consider other evidence, including a certificate of graduation from an accredited driving school with a recommendation that the ward should be extended driving privileges.
- Stipulates that if the court grants the order terminating the suspension or revocation and reinstates the privilege, the ward may apply to the Department of Transportation for the issuance or reinstatement of a driver license and requires the ward to comply with all department rules.
- States that any order terminating a temporary or permanent guardianship is an order terminating any previously adjudicated incapacity and vacates any previous order to suspend or revoke the ward's privilege to obtain or retain a driver's license.
- Permits the ward to apply to the Department of Transportation for the issuance or reinstatement of a driver license and requires the ward to comply with all department rules.

Guardian Powers

- Broadens the basis whereby a court is permitted to authorize a guardian to consent for inpatient mental health care and treatment to include the showing of clear and convincing evidence that the ward is incapacitated as a result of a mental disorder and is likely to be in need of inpatient mental health care and treatment within a one year period.
- Requires that the evaluation report indicate if the ward will likely need inpatient mental health care and treatment within a one year period.
- Terminates the guardian's authority to consent to treatment if the guardian does not file the evaluation report or indicates that the ward will not likely need inpatient mental health care and treatment.
- Permits the court to continue the guardian's authority to consent if the report supports the continuation of the guardian's authority to consent to inpatient treatment.
- States that, if the ward contests the continuation of the guardian's authority to consent to inpatient treatment, then the guardian has the burden of proving by clear and convincing evidence that the ward is likely to be in need of inpatient mental health care and treatment within the period of authority granted by law.

Court Options in an Involuntary Commitment Proceeding

- Broadens the basis whereby a court is permitted to order an investigation concerning the need for a guardian or conservator, or both, to include an order of the following findings, by clear and convincing evidence:

- That the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely or gravely disabled and in need of treatment and there exists a reasonable cause to believe that the patient is an incapacitated person or is in need of protection.
- Limits the people whom the court may appoint to investigate the need for a guardian or conservator to a court appointed guardian ad litem and an investigator qualified as defined in A.R.S. § 14-5308.
- Removes the requirement that the court appoint as an investigator the mental health treatment agency that is providing inpatient or outpatient treatment and court appointed visitor.
- Broadens the basis whereby an order for a temporary guardian or conservator may be issued to include the following grounds:
- The patient, as result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment.
- There is reasonable cause to believe that the patient is an incapacitated person as defined by law.
- The patient does not have a guardian or conservator and the welfare of the patient requires immediate action to protect the patient or the ward's property.
- The conditions prescribed in the sections of law governing the court's ability to enter a finding of interim incapacity
- Permits the court to appoint as a temporary guardian or conservator a suitable person or the public fiduciary if there is no person qualified and willing to act in that capacity.
- Requires that the court take the following actions when an issue an order for investigation and appoint an attorney to represent the patient in further proceedings regarding the appointment of a guardian or conservator, unless the patient is represented by independent counsel:
- Schedule a hearing, within 14 days, on the calendar of a court that has authority over guardianship or conservatorship matters to consider the need and appropriateness of an emergency temporary guardian or conservator.
- Order the temporary guardian or conservator to give notice to those who are statutorily entitled.
- Authorize certified letters of temporary emergency guardianship or conservatorship to be issued on presentation of a copy of the court's order.
- Stipulates that if a temporary emergency conservator other than the public fiduciary is appointed, the use of money and property of the patient by the conservator is to be restricted and not to be sold, used, transferred, or encumbered.
- Permits the court to authorize the conservator to use money or property of the patient specifically identified as needed to provide for the care, treatment or welfare of the patient, pending further hearing.
- Clarifies that the subsection does not prevent or relieve the evaluation or treatment agency from the following duties:
- Seeking guardianship and conservatorship in any other manner allowed by law at any during the period of court-ordered evaluation and treatment.
- Its obligations concerning the suspected abuse of a vulnerable adult pursuant to title 46, chapter 4.
- Broadens the basis by which the court may impose additional duties on an appointed guardian by including the following grounds:
- The patient, as result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment.
- There is reasonable cause to believe that the patient is an incapacitated person as defined by law.
- The patient does not have a guardian or conservator and the welfare of the patient requires immediate action to protect the patient or the ward's property.
- The conditions prescribed in the sections of law governing the court's ability to enter a finding of interim incapacity

- Permits the court to determine whether the patient needs to continue treatment under a court order or if the patient's needs can be adequately met by the guardian with the additional duties.
- Allows the court to terminate the court order for treatment if it finds that the court ordered treatment is no longer necessary to assure compliance with necessary treatment.
- Establishes that, unless the court orders otherwise, if there is a simultaneous court order treatment and a guardianship with additional mental health authority existing at the same time, the decisions by the treatment agency regarding the treatment and placement of the patient are controlling.
- Authorizes a guardian, who possesses additional mental health authority, the ability to request a judicial review of treatment or placement decisions made by the treatment agency.
- Makes technical and conforming changes.

HOUSE OF REPRESENTATIVES
HB 2402
guardians of incapacitated persons
Sponsors: Representative Vogt

DPA	Committee on Judiciary
X	Caucus and COW
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OVERVIEW

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Finally, A.R.S. § 36-540 currently allows the court to impose on an existing guardian the authority to admit the ward to a level one behavioral health facility for inpatient treatment (commonly referred to as a Mental Health Guardianship).

PROVISIONS

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- Permits the court, on the appointment of a guardian, to determine whether the ward's driver's license is to be suspended.
- Allows the court to decline to suspend the ward's privilege to obtain or retain a driver's license if the court is presented with sufficient medical or other evidence to establish that the ward's incapacity does not prevent the ward's ability to safely operate a motor vehicle.
- States that unless the court finds a ward's ability to drive safely is affected by a finding of interim incapacity and that that the driver's license should be suspended, then a finding of interim incapacity will not cause the ward's driving privilege to be suspended.
    - Permits the court, in lieu of ordering the ward's driver license suspended, to order the ward not to drive a motor vehicle until the ward presents sufficient evidence to establish that the ward's interim incapacity does not affect their ability to safely operate a motor vehicle.
    - Allows the ward to present the medical or other evidence by motion to the court.
    - Authorizes the court to rule on the motion without a hearing if there are no objections to the motion.
- Permits a ward, whose privilege to obtain or retain a driver's license has been suspended by a court order, to file a request to terminate the suspension or revocation and reinstate the privilege.
- Requires the court, in reaching its decision, to consider medical evidence that the ward's incapacity does not prevent the ward from safely operating a motor vehicle.
- Permits the court to, in reaching its decision, consider other evidence, including a certificate of graduation from an accredited driving school with a recommendation that the ward should be extended driving privileges.
- Stipulates that if the court grants the order terminating the suspension or revocation and reinstates the privilege, the ward may apply to the Department of Transportation for the issuance or reinstatement of a driver license and requires the ward to comply with all department rules.
- States that any order terminating a temporary or permanent guardianship is an order terminating any previously adjudicated incapacity and vacates any previous order to suspend or revoke the ward's privilege to obtain or retain a driver's license.
- Permits the ward to apply to the Department of Transportation for the issuance or reinstatement of a driver license and requires the ward to comply with all department rules.

Guardian Powers

- Broadens the basis whereby a court is permitted to authorize a guardian to consent for inpatient mental health care and treatment to include the showing of clear and convincing evidence that the ward is incapacitated as a result of a mental disorder and is likely to be in need of inpatient mental health care and treatment within a one year period.
- Requires that the evaluation report indicate if the ward will likely need inpatient mental health care and treatment within a one year period.
- Terminates the guardian's authority to consent to treatment if the guardian does not file the evaluation report or indicates that the ward will not likely need inpatient mental health care and treatment.

- Permits the court to continue the guardian's authority to consent if the report supports the continuation of the guardian's authority to consent to inpatient treatment.
- States that, if the ward contests the continuation of the guardian's authority to consent to inpatient treatment, then the guardian has the burden of proving by clear and convincing evidence that the ward is likely to be in need of inpatient mental health care and treatment within the period of authority granted by law.

Court Options in an Involuntary Commitment Proceeding

- Broadens the basis whereby a court is permitted to order an investigation concerning the need for a guardian or conservator, or both, to include an order of the following findings, by clear and convincing evidence:
  - That the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely or gravely disabled and in need of treatment and there exists a reasonable cause to believe that the patient is an incapacitated person or is in need of protection.
- Limits the people whom the court may appoint to investigate the need for a guardian or conservator to a court appointed guardian ad litem and an investigator qualified as defined in A.R.S. § 14-5308.
- Removes the requirement that the court appoint as an investigator the mental health treatment agency that is providing inpatient or outpatient treatment and court appointed visitor.
- Broadens the basis whereby an order for a temporary guardian or conservator may be issued to include the following grounds:
  - The patient, as result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment. There is reasonable cause to believe that the patient is an incapacitated person as defined by law.
  - The patient does not have a guardian or conservator and the welfare of the patient requires immediate action to protect the patient or the ward's property.
  - The conditions prescribed in the sections of law governing the court's ability to enter a finding of interim incapacity
- Permits the court to appoint as a temporary guardian or conservator a suitable person or the public fiduciary if there is no person qualified and willing to act in that capacity.
- Requires that the court take the following actions when an issue an order for investigation and appoint an attorney to represent the patient in further proceedings regarding the appointment of a guardian or conservator, unless the patient is represented by independent counsel:
  - Schedule a hearing, within 14 days, on the calendar of a court that has authority over guardianship or conservatorship matters to consider the need and appropriateness of an emergency temporary guardian or conservator.
  - Order the temporary guardian or conservator to give notice to those who are statutorily entitled.
  - Authorize certified letters of temporary emergency guardianship or conservatorship to be issued on presentation of a copy of the court's order.
  - Stipulates that if a temporary emergency conservator other than the public fiduciary is appointed, the use of money and property of the patient by the conservator is to be restricted and not to be sold, used, transferred, or encumbered.
- Permits the court to authorize the conservator to use money or property of the patient specifically identified as needed to provide for the care, treatment or welfare of the patient, pending further hearing.
- Clarifies that the subsection does not prevent or relieve the evaluation or treatment agency from the following duties:

    - Seeking guardianship and conservatorship in any other manner allowed by law at any during the period of court-ordered evaluation and treatment.
    - Its obligations concerning the suspected abuse of a vulnerable adult pursuant to title 46, chapter 4.
- Broadens the basis by which the court may impose additional duties on an appointed guardian by including the following grounds:
    - The patient, as result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely
    - There is reasonable cause to believe that the patient is an incapacitated person as defined by law.
    - The patient does not have a guardian or conservator and the welfare of the patient requires immediate action to protect the patient or the ward's property.
    - The conditions prescribed in the sections of law governing the court's ability to enter a finding of interim incapacity
- Permits the court to determine whether the patient needs to continue treatment under a court order or if the patient's needs can be adequately met by the guardian with the additional duties.
- Allows the court to terminate the court order for treatment if it finds that the court ordered treatment is no longer necessary to assure compliance with necessary treatment.
- Establishes that, unless the court orders otherwise, if there is a simultaneous court order treatment and a guardianship with additional mental health authority existing at the same time, the decisions by the treatment agency regarding the treatment and placement of the patient are controlling.
- Authorizes a guardian, who possesses additional mental health authority, the ability to request a judicial review of treatment or placement decisions made by the treatment agency.
- Makes technical and conforming changes.

AMENDMENTS

Committee on Judiciary

- Removes the section of the bill that authorizes a guardian, who possesses additional mental health authority, the ability to request a judicial review of treatment or placement decisions made by the treatment agency

Fiftieth Legislature, First Regular Session
COMMITTEE ON JUDICIARY

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2402
(Reference to printed bill)

Page 11, line 42, after the period strike remainder of line; strike lines 43 through 45
Amend title to conform

and, as so amended, it do pass

EDWIN W. FARNSWORTH
Chairman

REFERENCE TITLE: AHCCCS; nonemergency transportation; reimbursement

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2507

Introduced by: Representative Seel

AN ACT

AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Section 36-2907, Arizona Revised Statutes, is amended to read:
START_STATUTE36-2907. Covered health and medical services; modifications; related delivery of service requirements; definition

A. **Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:**
   1. **Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.**
   2. **Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.**
   3. **Other laboratory and x-ray services ordered by a physician or a primary care practitioner.**
   4. **Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1, 2006,~~ Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.**
   5. **Medical supplies, durable medical equipment and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.**
   6. **For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.**

7. **Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.**
8. **Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.**
9. **Podiatry services ordered by a primary care physician or primary care practitioner.**
10. **Nonexperimental transplants approved for title XIX reimbursement.**
11. **Ambulance and nonambulance transportation, except as provided in subsection G of this section.**

B. **The limitations and exclusions for health and medical services provided under this section are as follows:**
1. **~~Beginning on October 1, 2002,~~ Circumcision of newborn males is not a covered health and medical service.**
2. **For eligible persons who are at least twenty-one years of age:**

a) **Outpatient health services do not include occupational therapy or speech therapy.**
b) **Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand ~~five-hundred~~ FIVE HUNDRED dollars per contract year.**
c) **Insulin pumps, percussive vests and orthotics are not covered health and medical services.**
d) **Durable medical equipment is limited to items covered by medicare.**
e) **Podiatry services do not include services performed by a podiatrist.**
f) **Nonexperimental transplants do not include the following:**
i. **Pancreas only transplants.**
ii. **Pancreas after kidney transplants.**
iii. **Lung transplants.**
iv. **Hemopoetic cell allogenic unrelated transplants.**
v. **Heart transplants for non-ischemic cardiomyopathy.**
vi. **Liver transplants for diagnosis of hepatitis C.**
g) **Beginning October 1, 2011, bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.**
h) **Well exams are not a covered health and medical service, except mammograms, pap smears and colonoscopies.**

C. **The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.**

D. **The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.**

E. **The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis**

by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.

F. **The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.**

G. **The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided to persons who are eligible pursuant to sections 36-2901.01 and 36-2901.04 and who reside in a county with a population of more than five hundred thousand persons. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems. THE ADMINISTRATION SHALL LIMIT REIMBURSEMENT FOR NONEMERGENCY TRANSPORTATION TO NOT MORE THAN THE COST OF BUS TRANSPORTATION IN REGIONS WHERE A SCHEDULED BUS SYSTEM IS AVAILABLE.**

H. **The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.**

I. **If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.**

J. **Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).**

K. **All health and medical services provided under this article shall be provided in the geographic service area of the member, except:**

1. **Emergency services and specialty services provided pursuant to section 36-2908.**
2. **That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the**

definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

L. **Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.**

M. **The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.**

N. **For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201. END_STATUTE**

HOUSE OF REPRESENTATIVES
HB 2510
palliative care; patient information.
Sponsors: Representatives Heinz: Patterson

DPA/SE	Committee on Health and Human Services
X	Caucus and COW
	House Engrossed

OVERVIEW

HB 2510 specifies that a physician or health care provider of a patient diagnosed with a terminal illness or condition offer to provide the patient with patient information and counseling regarding palliative care.

Summary of Proposed Strike-Everything Amendment to HB 2510

HB 2510 expands the definition of *dangerous drugs* to include specific chemical compounds that typically compose "bath salts".

HISTORY

The U.S. Department of Justice states in a Drug Alert Watch report dated December 17, 2010 a recreational drug called "bath salts" is being abused as a recreational drug. Users of bath salts are typically injecting, smoking, and snorting the drug with street names such as "blue majic", "blue silk" and "ivory snow". The drug is currently being sold in head shops, tobacco shops, various retail outlets, and over the internet.

Currently "bath salts" are legal in most states, with many taking steps to make the drugs illegal. Testing done so far indicates that the active ingredients in "bath salts" are methylenedioxypyrovalerone and/or mephedrone. The use of the "bath salts" has caused, in its users, increased heart rate, agitation, diminished requirement for sleep, lack of appetite, increased alertness, anxiety, nosebleeds, fits and delusions.

Arizona Revised Statutes (A.R.S.) § 13-3401 currently defines a *dangerous drug* as any material, compound, mixture or preparation that contains hallucinogenic substances; stimulants or depressants with potential for abuse; or anabolic steroids.

A.R.S. § 13-3407 specifies the criminal classifications and penalties for the possession, use, administration, acquisition, sale, manufacturing, or transportation of dangerous drugs.

PROVISIONS

- Expands the definition of *dangerous drugs* to include three chemical compounds that compose "bath salts"
- Amends the list of controlled substances under Schedule I of the Arizona Uniform Controlled Substances Act (A.R.S. Title 36, Chapter 27, Article 2) to conform to the additions made in the definition of dangerous drugs under A.R.S. § 13-3401.

Amendments

Health and Human Services Committee

- The strike-everything amendment was adopted.
- Contains an emergency clause.

HOUSE OF REPRESENTATIVES
HB 2510
palliative care; patient information.
Sponsors: Representatives Heinz: Patterson

X	Committee on Health and Human Services
	Caucus and COW
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REFERENCE TITLE: palliative care; patient information.

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2510

Introduced by: Representatives Heinz: Patterson

AN ACT

AMENDING TITLE 32, CHAPTER 32, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 3; RELATING TO PALLIATIVE CARE PATIENT INFORMATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:
Section 1. Title 32, chapter 32, Arizona Revised Statutes, is amended by adding article 3, to read:
ARTICLE 3. PALLIATIVE CARE PATIENT INFORMATION
START_STATUTE32-3241. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. **"APPROPRIATE" MEANS CONSISTENT WITH APPLICABLE LEGAL, HEALTH AND PROFESSIONAL STANDARDS, THE PATIENT'S CLINICAL AND OTHER CIRCUMSTANCES AND THE PATIENT'S REASONABLY KNOWN WISHES AND BELIEFS.**
2. **"ATTENDING HEALTH CARE PRACTITIONER" MEANS A PHYSICIAN WHO IS LICENSED PURSUANT TO CHAPTER 13 OR 17 OF THIS TITLE, OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO CHAPTER 15 OF THIS TITLE, AND WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE AND TREATMENT OF THE PATIENT.**
3. **"PALLIATIVE CARE" MEANS HEALTH CARE TREATMENT, INCLUDING INTERDISCIPLINARY END-OF-LIFE CARE AND CONSULTATION WITH PATIENTS AND FAMILY MEMBERS, TO PREVENT OR RELIEVE PAIN AND SUFFERING AND TO ENHANCE THE PATIENT'S QUALITY OF LIFE. PALLIATIVE CARE INCLUDES HOSPICE CARE.**
4. **"TERMINAL ILLNESS OR CONDITION" MEANS AN ILLNESS OR CONDITION THAT CAN REASONABLY BE EXPECTED TO CAUSE DEATH WITHIN SIX MONTHS, WHETHER OR NOT TREATMENT IS PROVIDED.**

END_STATUTE

START_STATUTE32-3242. Terminally ill patients; palliative care; attending health care practitioner responsibilities

A. **IF A PATIENT IS DIAGNOSED WITH A TERMINAL ILLNESS OR CONDITION, THE PATIENT'S ATTENDING HEALTH CARE PRACTITIONER SHALL OFFER TO PROVIDE THE PATIENT WITH INFORMATION AND COUNSELING REGARDING PALLIATIVE CARE AND END-OF-LIFE OPTIONS APPROPRIATE TO THE PATIENT, INCLUDING:**
   1. **THE RANGE OF OPTIONS APPROPRIATE TO THE PATIENT.**
   2. **THE PROGNOSIS, RISKS AND BENEFITS OF THE VARIOUS OPTIONS.**
   3. **THE PATIENT'S LEGAL RIGHTS TO COMPREHENSIVE PAIN AND SYMPTOM MANAGEMENT AT THE END OF LIFE.**

B. **THE ATTENDING HEALTH CARE PRACTITIONER MAY PROVIDE THE INFORMATION REQUIRED PURSUANT TO THIS SECTION ORALLY OR IN WRITING.**

C. **IF THE PATIENT LACKS CAPACITY TO REASONABLY UNDERSTAND AND MAKE INFORMED CHOICES RELATING TO PALLIATIVE CARE, THE ATTENDING HEALTH CARE PRACTITIONER SHALL PROVIDE INFORMATION AND COUNSELING REQUIRED PURSUANT TO THIS SECTION TO A PERSON WHO HAS THE AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR THE PATIENT.**

D. **THE ATTENDING HEALTH CARE PRACTITIONER MAY ARRANGE FOR INFORMATION AND COUNSELING REQUIRED PURSUANT TO THIS SECTION TO BE PROVIDED BY ANOTHER PROFESSIONALLY QUALIFIED INDIVIDUAL.**

E. **IF THE ATTENDING HEALTH CARE PRACTITIONER IS NOT WILLING TO PROVIDE THE PATIENT WITH INFORMATION AND COUNSELING REQUIRED PURSUANT TO THIS SECTION, THE ATTENDING HEALTH CARE PRACTITIONER SHALL ARRANGE FOR ANOTHER HEALTH CARE PRACTITIONER TO DO SO OR SHALL REFER OR TRANSFER THE PATIENT TO ANOTHER ATTENDING HEALTH CARE PRACTITIONER WILLING TO DO SO.**

F. **IF MORE THAN ONE PHYSICIAN OR NURSE PRACTITIONER SHARE PRIMARY RESPONSIBILITY FOR THE CARE AND TREATMENT OF THE PATIENT, EACH OF THEM HAS RESPONSIBILITY TO PROVIDE THE INFORMATION REQUIRED PURSUANT TO THIS SECTION UNLESS THEY AGREE TO ASSIGN THAT RESPONSIBILITY TO ONLY ONE OF THEM.**

END_STATUTE

Fiftieth Legislature, First Regular Session
COMMITTEE ON HEALTH AND HUMAN SERVICES

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2510
(Reference to printed bill)

Strike everything after the enacting clause and insert:
"Section 1. Section 13-3401, Arizona Revised Statutes, is amended to read:
START_STATUTE13-3401. Definitions

In this chapter, unless the context otherwise requires:

1. **"Administer" means to apply, inject or facilitate the inhalation or ingestion of a substance to the body of a person.**
2. **"Amidone" means any substance identified chemically as (4-4-diphenyl-6-dimethylamine-heptanone-3), or any salt of such substance, by whatever trade name designated.**
3. **"Board" means the Arizona state board of pharmacy.**

4. **"Cannabis" means the following substances under whatever names they may be designated:**
   a) **The resin extracted from any part of a plant of the genus cannabis, and every compound, manufacture, salt, derivative, mixture or preparation of such plant, its seeds or its resin. Cannabis does not include oil or cake made from the seeds of such plant, any fiber, compound, manufacture, salt, derivative, mixture or preparation of the mature stalks of such plant except the resin extracted from the stalks or any fiber, oil or cake or the sterilized seed of such plant which is incapable of germination.**
   b) **Every compound, manufacture, salt, derivative, mixture or preparation of such resin or tetrahydrocannabinol.**
5. **"Coca leaves" means cocaine, its optical isomers and any compound, manufacture, salt, derivative, mixture or preparation of coca leaves, except derivatives of coca leaves which do not contain cocaine, ecgonine or substances from which cocaine or ecgonine may be synthesized or made.**
6. **"Dangerous drug" means the following by whatever official, common, usual, chemical or trade name designated:**

   a) **Any material, compound, mixture or preparation which contains any quantity of the following hallucinogenic substances and their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:**
      i. **Alpha-ethyltryptamine.**
      ii. **Aminorex.**
      iii. **4-bromo-2, 5-dimethoxyphenethylamine.**
      iv. **4-bromo-2, 5-dimethoxyamphetamine.**
      v. **Bufotenine.**
      vi. **Diethyltryptamine.**
      vii. **2, 5-dimethoxyamphetamine.**
      viii. **Dimethyltryptamine.**
      ix. **5-methoxy-3, 4-methylenedioxyamphetamine.**
      x. **4-methyl-2, 5-dimethoxyamphetamine.**
      xi. **Ibogaine.**
      xii. **Lysergic acid amide.**
      xiii. **Lysergic acid diethylamide.**
      xiv. **Mescaline.**
      xv. **4-methoxyamphetamine.**
      xvi. **Methoxymethylenedioxyamphetamine (MMDA).**
      xvii. **Methylenedioxyamphetamine (MDA).**
      xviii. **3, 4-methylenedioxymethamphetamine.**
      xix. **3, 4-methylenedioxy-N-ethylamphetamine.**
      xx. **N-ethyl-3-piperidyl benzilate (JB-318).**
      xxi. **N-hydroxy-3, 4-methylenedioxyamphetamine.**
      xxii. **N-methyl-3-piperidyl benzilate (JB-336).**
      xxiii. **N-(1-phenylcyclohexyl) ethylamine (PCE).**
      xxiv. **Nabilone.**
      xxv. **1-(1-phenylcyclohexyl) pyrrolidine (PHP).**
      xxvi. **1-(1-(2-thienyl)-cyclohexyl) piperidine (TCP).**
      xxvii. **1-(1-(2-thienyl)-cyclohexyl) pyrrolidine.**
      xxviii. **Para-methoxyamphetamine (PMA).**
      xxix. **Psilocybin.**
      xxx. **Psilocyn.**
      xxxi. **Synhexyl.**

xxxii. **Trifluoromethylphenylpiperazine (TFMPP).**
xxxiii. **Trimethoxyamphetamine (TMA).**

b) **Any material, compound, mixture or preparation which contains any quantity of the following substances and their salts, optical isomers, and salts of optical isomers having a potential for abuse associated with a stimulant effect on the central nervous system:**

i. **Amphetamine.**
ii. **Benzphetamine.**
iii. **Benzylpiperazine (BZP).**
iv. **Butorphanol.**
v. **Cathine ((+)-norpseudoephedrine).**
vi. **Cathinone.**
vii. **Chlorphentermine.**
viii. **Clortermine.**
ix. **Diethylpropion.**
x. **Fencamfamin.**
xi. **Fenethylline.**
xii. **Fenproporex.**
xiii. **Mazindol.**
xiv. **Mefenorex.**
xv. **Methamphetamine.**
xvi. **4-methylaminorex.**
(xviii) METHYLENEDIOXYMETHCATHINONE.
(xix) METHYLENEDIOXYPYROVALERONE.
(xx) METHYLMETHCATHINONE.
~~**(xviii)**~~ **(xxi) Methylphenidate.**
~~**(xix)**~~ **(xxii) Modafinil.**
~~**(xx)**~~ **(xxiii) N-ethylamphetamine.**
~~**(xxi)**~~ **(xxiv) N, N-dimethylamphetamine.**
~~**(xxii)**~~ **(xxv) Pemoline.**
~~**(xxiii)**~~ **(xxvi) Phendimetrazine.**
~~**(xxiv)**~~ **(xxvii) Phenmetrazine.**
~~**(xxv)**~~ **(xxviii) Phentermine.**
~~**(xxvi)**~~ **(xxix) Pipradol.**
~~**(xxvii)**~~ **(xxx) Propylhexedrine.**
~~**(xxviii)**~~ **(xxxi) Pyrovalerone.**
~~**(xxix)**~~ **(xxxii) Sibutramine.**
~~**(xxx)**~~ **(xxxiii) Spa ((-)-1-dimethylamino-1,2-diphenylethane).**

c) **Any material, compound, mixture or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:**

i. **Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid, unless specifically excepted.**
ii. **Alprazolam.**
iii. **Bromazepam.**
iv. **Camazepam.**
v. **Carisoprodol.**
vi. **Chloral betaine.**
vii. **Chloral hydrate.**
viii. **Chlordiazepoxide.**
ix. **Chlorhexadol.**
x. **Clobazam.**

xi. **Clonazepam.**
xii. **Clorazepate.**
xiii. **Clotiazepam.**
xiv. **Cloxazolam.**
xv. **Delorazepam.**
xvi. **Diazepam.**
xvii. **Dichloralphenazone.**
xviii. **Estazolam.**
xix. **Ethchlorvynol.**
xx. **Ethinamate.**
xxi. **Ethyl loflazepate.**
xxii. **Fenfluramine.**
xxiii. **Fludiazepam.**
xxiv. **Flunitrazepam.**
xxv. **Flurazepam.**
xxvi. **Gamma hydroxy butyrate.**
xxvii. **Glutethimide.**
xxviii. **Halazepam.**
xxix. **Haloxazolam.**
xxx. **Ketamine.**
xxxi. **Ketazolam.**
xxxii. **Loprazolam.**
xxxiii. **Lorazepam.**
xxxiv. **Lormetazepam.**
xxxv. **Lysergic acid.**
xxxvi. **Mebutamate.**
xxxvii. **Mecloqualone.**
xxxviii. **Medazepam.**
xxxix. **Meprobamate.**
xl. **Methaqualone.**
xli. **Methohexital.**
xlii. **Methyprylon.**
xliii. **Midazolam.**
xliv. **Nimetazepam.**
xlv. **Nitrazepam.**
xlvi. **Nordiazepam.**
xlvii. **Oxazepam.**
xlviii. **Oxazolam.**
xlix. **Paraldehyde.**
l. **Petrichloral.**
li. **Phencyclidine.**
lii. **Pinazepam.**
liii. **Prazepam.**
liv. **Scopolamine.**
lv. **Sulfondiethylmethane.**
lvi. **Sulfonethylmethane.**
lvii. **Sulfonmethane.**
lviii. **Quazepam.**
lix. **Temazepam.**
lx. **Tetrazepam.**
lxi. **Tiletamine.**

lxii. **Triazolam.**
lxiii. **Zaleplon.**
lxiv. **Zolazepam.**
lxv. **Zolpidem.**

d) **Any material, compound, mixture or preparation which contains any quantity of the following anabolic steroids and their salts, isomers or esters:**
i. **Boldenone.**
ii. **Clostebol (4-chlorotestosterone).**
iii. **Dehydrochloromethyltestosterone.**
iv. **Drostanolone.**
v. **Ethylestrenol.**
vi. **Fluoxymesterone.**
vii. **Formebulone (formebolone).**
viii. **Mesterolone.**
ix. **Methandriol.**
x. **Methandrostenolone (methandienone).**
xi. **Methenolone.**
xii. **Methyltestosterone.**
xiii. **Mibolerone.**
xiv. **Nandrolone.**
xv. **Norethandrolon.**
xvi. **Oxandrolone.**
xvii. **Oxymesterone.**
xviii. **Oxymetholone.**
xix. **Stanolone (4-dihydrotestosterone).**
xx. **Stanozolol.**
xxi. **Testolactone.**
xxii. **Testosterone.**
xxiii. **Trenbolone.**

7. **"Deliver" means the actual, constructive or attempted exchange from one person to another, whether or not there is an agency relationship.**
8. **"Director" means the director of the department of health services.**
9. **"Dispense" means distribute, leave with, give away, dispose of or deliver.**
10. **"Drug court program" means a program that is established pursuant to section 13-3422 by the presiding judge of the superior court in cooperation with the county attorney in a county for the purpose of prosecuting, adjudicating and treating drug dependent persons who meet the criteria and guidelines for entry into the program that are developed and agreed on by the presiding judge and the prosecutor.**
11. **"Drug dependent person" means a person who is using a substance that is listed in paragraph 6, 19, 20, 21 or 28 of this section and who is in a state of psychological or physical dependence, or both, arising from the use of that substance.**
12. **"Federal act" has the same meaning prescribed in section 32-1901.**
13. **"Isoamidone" means any substance identified chemically as (4-4-diphenyl-5-methyl-6-dimethylaminohexanone-3), or any salt of such substance, by whatever trade name designated.**
14. **"Isonipecaine" means any substance identified chemically as (1-methyl-4-phenyl-piperidine-4-carboxylic acid ethyl ester), or any salt of such substance, by whatever trade name designated.**
15. **"Ketobemidone" means any substance identified chemically as (4-(3-hydroxyphenyl)-1-methyl-4-piperidylethyl ketone hydrochloride), or any salt of such substance, by whatever trade name designated.**

16. **"Licensed" or "permitted" means authorized by the laws of this state to do certain things.**
17. **"Manufacture" means produce, prepare, propagate, compound, mix or process, directly or indirectly, by extraction from substances of natural origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Manufacture includes any packaging or repackaging or labeling or relabeling of containers. Manufacture does not include any producing, preparing, propagating, compounding, mixing, processing, packaging or labeling done in conformity with applicable state and local laws and rules by a licensed practitioner incident to and in the course of his licensed practice.**
18. **"Manufacturer" means a person who manufactures a narcotic or dangerous drug or other substance controlled by this chapter.**
19. **"Marijuana" means all parts of any plant of the genus cannabis, from which the resin has not been extracted, whether growing or not, and the seeds of such plant. Marijuana does not include the mature stalks of such plant or the sterilized seed of such plant which is incapable of germination.**
20. **"Narcotic drugs" means the following, whether of natural or synthetic origin and any substance neither chemically nor physically distinguishable from them:**
    a) **Acetyl-alpha-methylfentanyl.**
    b) **Acetylmethadol.**
    c) **Alfentanil.**
    d) **Allylprodine.**
    e) **Alphacetylmethadol.**
    f) **Alphameprodine.**
    g) **Alphamethadol.**
    h) **Alpha-methylfentanyl.**
    i) **Alpha-methylthiofentanyl.**
    j) **Alphaprodine.**
    k) **Amidone (methadone).**
    l) **Anileridine.**
    m) **Benzethidine.**
    n) **Benzylfentanyl.**
    o) **Betacetylmethadol.**
    p) **Beta-hydroxyfentanyl.**
    q) **Beta-hydroxy-3-methylfentanyl.**
    r) **Betameprodine.**
    s) **Betamethadol.**
    t) **Betaprodine.**
    u) **Bezitramide.**
    v) **Buprenorphine and its salts.**
    w) **Cannabis.**
    x) **Carfentanil.**
    y) **Clonitazene.**
    z) **Coca leaves.**
    aa) **Dextromoramide.**
    bb) **Dextropropoxyphene.**
    cc) **Diampromide.**
    dd) **Diethylthiambutene.**
    ee) **Difenoxin.**
    ff) **Dihydrocodeine.**
    gg) **Dimenoxadol.**
    hh) **Dimepheptanol.**

ii) **Dimethylthiambutene.**
jj) **Dioxaphetyl butyrate.**
kk) **Diphenoxylate.**
ll) **Dipipanone.**
mm) **Ethylmethylthiambutene.**
nn) **Etonitazene.**
oo) **Etoxeridine.**
pp) **Fentanyl.**
qq) **Furethidine.**
rr) **Hydroxypethidine.**
ss) **Isoamidone (isomethadone).**
tt) **Pethidine (meperidine).**
uu) **Ketobemidone.**
vv) **Levomethorphan.**
ww) **Levomoramide.**
xx) **Levophenacylmorphan.**
yy) **Levorphanol.**
zz) **Metazocine.**
aaa) **3-methylfentanyl.**
bbb) **1-methyl-4-phenyl-4-propionoxypiperidine (MPPP).**
ccc) **3-methylthiofentanyl.**
ddd) **Morpheridine.**
eee) **Noracymethadol.**
fff) **Norlevorphanol.**
ggg) **Normethadone.**
hhh) **Norpipanone.**
iii) **Opium.**
jjj) **Para-fluorofentanyl.**
kkk) **Pentazocine.**
lll) **Phenadoxone.**
mmm) **Phenampromide.**
nnn) **Phenazocine.**
ooo) **1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine (PEPAP).**
ppp) **Phenomorphan.**
qqq) **Phenoperidine.**
rrr) **Piminodine.**
sss) **Piritramide.**
ttt) **Proheptazine.**
uuu) **Properidine.**
vvv) **Propiram.**
www) **Racemethorphan.**
xxx) **Racemoramide.**
yyy) **Racemorphan.**
zzz) **Remifentanil.**
aaaa) **Sufentanil.**
bbbb) **Thenylfentanyl.**
cccc) **Thiofentanyl.**
dddd) **Tilidine.**
eeee) **Trimeperidine.**

21. **"Opium" means any compound, manufacture, salt, isomer, salt of isomer, derivative, mixture or preparation of the following, but does not include apomorphine or any of its salts:**
    a) **Acetorphine.**
    b) **Acetyldihydrocodeine.**
    c) **Benzylmorphine.**
    d) **Codeine.**
    e) **Codeine methylbromide.**
    f) **Codeine-N-oxide.**
    g) **Cyprenorphine.**
    h) **Desomorphine.**
    i) **Dihydromorphine.**
    j) **Drotebanol.**
    k) **Ethylmorphine.**
    l) **Etorphine.**
    m) **Heroin.**
    n) **Hydrocodone.**
    o) **Hydromorphinol.**
    p) **Hydromorphone.**
    q) **Levo-alphacetylmethadol.**
    r) **Methyldesorphine.**
    s) **Methyldihydromorphine.**
    t) **Metopon.**
    u) **Morphine.**
    v) **Morphine methylbromide.**
    w) **Morphine methylsulfonate.**
    x) **Morphine-N-oxide.**
    y) **Myrophine.**
    z) **Nalorphine.**
    aa) **Nicocodeine.**
    bb) **Nicomorphine.**
    cc) **Normorphine.**
    dd) **Oxycodone.**
    ee) **Oxymorphone.**
    ff) **Pholcodine.**
    gg) **Thebacon.**
    hh) **Thebaine.**
22. **"Ordinary ephedrine, pseudoephedrine, (-)-norpseudoephedrine or phenylpropanolamine product" means a product that contains ephedrine, pseudoephedrine, (-)-norpseudoephedrine or phenylpropanolamine and that is all of the following:**
    a) **Approved for sale under the federal act.**
    b) **Labeled, advertised and marketed only for an indication that is approved by the federal food and drug administration.**
    c) **Either:**
        i. **A nonliquid that is sold in package sizes of not more than three grams of ephedrine, pseudoephedrine, (-)-norpseudoephedrine or phenlypropanolamine and that is packaged in blister packs containing not more than two dosage units or, if the use of blister packs is technically infeasible, that is packaged in unit dose packets or pouches.**
        ii. **A liquid that is sold in package sizes of not more than three grams of ephedrine, pseudoephedrine, (-)-norpseudoephedrine or phenylpropanolamine.**
23. **"Peyote" means any part of a plant of the genus lophophora, known as the mescal button.**

24. **"Pharmacy" means a licensed business where drugs are compounded or dispensed by a licensed pharmacist.**
25. **"Practitioner" means a person licensed to prescribe and administer drugs.**
26. **"Precursor chemical I" means any material, compound, mixture or preparation which contains any quantity of the following substances and their salts, optical isomers or salts of optical isomers:**
    a) **N-acetylanthranilic acid.**
    b) **Anthranilic acid.**
    c) **Ephedrine.**
    d) **Ergotamine.**
    e) **Isosafrole.**
    f) **Lysergic acid.**
    g) **Methylamine.**
    h) **N-ethylephedrine.**
    i) **N-ethylpseudoephedrine.**
    j) **N-methylephedrine.**
    k) **N-methylpseudoephedrine.**
    l) **Norephedrine.**
    m) **(-)-Norpseudoephedrine.**
    n) **Phenylacetic acid.**
    o) **Phenylpropanolamine.**
    p) **Piperidine.**
    q) **Pseudoephedrine.**
27. **"Precursor chemical II" means any material, compound, mixture or preparation which contains any quantity of the following substances and their salts, optical isomers or salts of optical isomers:**
    a) **4-cyano-2-dimethylamino-4, 4-diphenyl butane.**
    b) **4-cyano-1-methyl-4-phenylpiperidine.**
    c) **Chlorephedrine.**
    d) **Chlorpseudoephedrine.**
    e) **Ethyl-4-phenylpiperidine-4-carboxylate.**
    f) **2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid.**
    g) **1-methyl-4-phenylpiperidine-4-carboxylic acid.**
    h) **N-formyl amphetamine.**
    i) **N-formyl methamphetamine.**
    j) **Phenyl-2-propanone.**
    k) **1-piperidinocyclohexane carbonitrile.**
    l) **1-pyrrolidinocyclohexane carbonitrile.**
28. **"Prescription-only drug" does not include a dangerous drug or narcotic drug but means:**
    a) **Any drug which because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not generally recognized among experts, qualified by scientific training and experience to evaluate its safety and efficacy, as safe for use except by or under the supervision of a medical practitioner.**
    b) **Any drug that is limited by an approved new drug application under the federal act or section 32-1962 to use under the supervision of a medical practitioner.**
    c) **Every potentially harmful drug, the labeling of which does not bear or contain full and adequate directions for use by the consumer.**
    d) **Any drug required by the federal act to bear on its label the legend "Caution: Federal law prohibits dispensing without prescription" or "Rx only".**
29. **"Produce" means grow, plant, cultivate, harvest, dry, process or prepare for sale.**

30. **"Regulated chemical" means the following substances in bulk form that are not a useful part of an otherwise lawful product:**
    a) **Acetic anhydride.**
    b) **Hypophosphorous acid.**
    c) **Iodine.**
    d) **Sodium acetate.**
    e) **Red phosphorus.**
    f) **Gamma butyrolactone (GBL).**
    g) **1, 4-butanediol.**
    h) **Butyrolactone.**
    i) **1, 2 butanolide.**
    j) **2-oxanalone.**
    k) **Tetrahydro-2-furanone.**
    l) **Dihydro-2(3H)-furanone.**
    m) **Tetramethylene glycol.**
31. **"Retailer" means either:**
    a) **A person other than a practitioner who sells any precursor chemical or regulated chemical to another person for purposes of consumption and not resale, whether or not the person possesses a permit issued pursuant to title 32, chapter 18.**
    b) **A person other than a manufacturer or wholesaler who purchases, receives or acquires more than twenty-four grams of a precursor chemical.**
32. **"Sale" or "sell" means an exchange for anything of value or advantage, present or prospective.**
33. **"Sale for personal use" means the retail sale for a legitimate medical use in a single transaction to an individual customer, to an employer for dispensing to employees from first aid kits or medicine chests or to a school for administration pursuant to section 15-344.**
34. **"Scientific purpose" means research, teaching or chemical analysis.**
35. **"Suspicious transaction" means a transaction to which any of the following applies:**
    a) **A report is required under the federal act.**
    b) **The circumstances would lead a reasonable person to believe that any person is attempting to possess a precursor chemical or regulated chemical for the purpose of unlawful manufacture of a dangerous drug or narcotic drug, based on such factors as the amount involved, the method of payment, the method of delivery and any past dealings with any participant.**
    c) **The transaction involves payment for precursor or regulated chemicals in cash or money orders in a total amount of more than two hundred dollars.**
    d) **The transaction involves a sale, a transfer or furnishing to a retailer for resale without a prescription of ephedrine, pseudoephedrine, (-)-norpseudoephedrine or phenylpropanolamine that is not an ordinary ephedrine, pseudoephedrine, (-)-norpseudoephedrine or phenylpropanolamine product.**
36. **"Threshold amount" means a weight, market value or other form of measurement of an unlawful substance as follows:**
    a) **One gram of heroin.**
    b) **Nine grams of cocaine.**
    c) **Seven hundred fifty milligrams of cocaine base or hydrolyzed cocaine.**
    d) **Four grams or 50 milliliters of PCP.**
    e) **Nine grams of methamphetamine, including methamphetamine in liquid suspension.**
    f) **Nine grams of amphetamine, including amphetamine in liquid suspension.**
    g) **One-half milliliter of lysergic acid diethylamide, or in the case of blotter dosage units fifty dosage units.**
    h) **Two pounds of marijuana.**

i) **For any combination consisting solely of those unlawful substances listed in subdivisions (a) through (h) of this paragraph, an amount equal to or in excess of the threshold amount, as determined by the application of section 13-3420.**

j) **For any unlawful substance not listed in subdivisions (a) through (h) of this paragraph or any combination involving any unlawful substance not listed in subdivisions (a) through (h) of this paragraph, a value of at least one thousand dollars.**

37. **"Transfer" means furnish, deliver or give away.**

38. **"Vapor-releasing substance containing a toxic substance" means a material which releases vapors or fumes containing any of the following:**

a) **Ketones, including acetone, methyl ethyl ketone, mibk, miak, isophorone and mesityl oxide.**

b) **Hydrocarbons, including propane, butane, pentane, hexane, heptane and halogenated hydrocarbons.**

c) **Ethylene dichloride.**

d) **Pentachlorophenol.**

e) **Chloroform.**

f) **Methylene chloride.**

g) **Trichloroethylene.**

h) **Difluoroethane.**

i) **Tetrafluoroethane.**

j) **Aldehydes, including formaldehyde.**

k) **Acetates, including ethyl acetate and butyl acetate.**

l) **Aromatics, including benzene, toluene, xylene, ethylbenzene and cumene.**

m) **Alcohols, including methyl alcohol, ethyl alcohol, isopropyl alcohol, butyl alcohol and diacetone alcohol.**

n) **Ether, including Diethyl ether and petroleum ether.**

o) **Nitrous oxide.**

p) **Amyl nitrite.**

q) **Isobutyl nitrite.**

39. **"Weight" unless otherwise specified includes the entire weight of any mixture or substance that contains a detectable amount of an unlawful substance. If a mixture or substance contains more than one unlawful substance, the weight of the entire mixture or substance is assigned to the unlawful substance that results in the greater offense. If a mixture or substance contains lysergic acid diethylamide, the offense that results from the unlawful substance shall be based on the greater offense as determined by the entire weight of the mixture or substance or the number of blotter dosage units. For the purposes of this paragraph, "mixture" means any combination of substances from which the unlawful substance cannot be removed without a chemical process.**

40. **"Wholesaler" means a person who in the usual course of business lawfully supplies narcotic drugs, dangerous drugs, precursor chemicals or regulated chemicals that he himself has not produced or prepared, but not to a person for the purpose of consumption by the person, whether or not the wholesaler has a permit that is issued pursuant to title 32, chapter 18. Wholesaler includes a person who sells, delivers or dispenses a precursor chemical in an amount or under circumstances that would require registration as a distributor of precursor chemicals under the federal act.**

END_STATUTE

Sec. 2. Section 36-2512, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2512. Substances in schedule I

A. **The following controlled substances are, unless specifically excepted, included in schedule I:**

1. **Any of the following, including opiates and their isomers, esters, ethers, salts and salts of isomers, esters and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:**
    a) **Acetyl-alpha-methylfentanyl.**
    b) **Allylprodine.**
    c) **Alpha-methylthiofentanyl.**
    d) **Alphacetylmethadol.**
    e) **Alphameprodine.**
    f) **Alphamethadol.**
    g) **Alpha-methylfentanyl.**
    h) **Benzethidine.**
    i) **Benzylfentanyl and its optical isomers, salts and salts of isomers.**
    j) **Beta-hydroxyfentanyl.**
    k) **Beta-hydroxy-3-methylfentanyl.**
    l) **Betacetylmethadol.**
    m) **Betameprodine.**
    n) **Betamethadol.**
    o) **Betaprodine.**
    p) **Clonitazene.**
    q) **Dextromoramide.**
    r) **Diampromide.**
    s) **Diethylthiambutene.**
    t) **Difenoxin.**
    u) **Dimenoxadol.**
    v) **Dimepheptanol.**
    w) **Dimethylthiambutene.**
    x) **Dioxaphetyl butyrate.**
    y) **Dipipanone.**
    z) **Ethylmethylthiambutene.**
    aa) **Etonitazene.**
    bb) **Etoxeridine.**
    cc) **4-methylaminorex.**
    dd) **Furethidine.**
    ee) **Hydroxypethidine.**
    ff) **Ketobemidone.**
    gg) **Levomoramide.**
    hh) **Levophenacylmorphan.**
    ii) **MPPP (1-methyl-4-phenyl-4-propionoxypiperidine).**
    jj) **Morpheridine.**
    kk) **Noracymethadol.**
    ll) **Norlevorphanol.**
    mm) **Normethadone.**
    nn) **Norpipanone.**
    oo) **Para-fluorofentanyl.**
    pp) **Pepap (1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine).**
    qq) **Phenadoxone.**
    rr) **Phenampromide.**
    ss) **Phenomorphan.**
    tt) **Phenoperidine.**
    uu) **Piritramide.**
    vv) **Proheptazine.**

ww) **Properidine.**
xx) **Propiram.**
yy) **Racemoramide.**
zz) **Thenylfentanyl and its optical isomers, salts and salts of isomers.**
aaa) **Thiofentanyl.**
bbb) **3-methylfentanyl.**
ccc) **3-methylthiofentanyl.**
ddd) **Tilidine.**
eee) **Trimeperidine.**

2. **Any of the following opium derivatives and their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:**
   a) **Acetorphine.**
   b) **Acetyldihydrocodeine.**
   c) **Benzylmorphine.**
   d) **Codeine methylbromide.**
   e) **Codeine-n-oxide.**
   f) **Cyprenorphine.**
   g) **Desomorphine.**
   h) **Dihydromorphine.**
   i) **Drotebanol.**
   j) **Etorphine, except hydrochloride salt.**
   k) **Heroin.**
   l) **Hydromorphinol.**
   m) **Methyldesorphine.**
   n) **Methyldihydromorphine.**
   o) **Morphine methylbromide.**
   p) **Morphine methylsulfonate.**
   q) **Morphine-n-oxide.**
   r) **Myrophine.**
   s) **Nicocodeine.**
   t) **Nicomorphine.**
   u) **Normorphine.**
   v) **Pholcodeine.**
   w) **Thebacon.**

3. **Any material, compound, mixture or preparation which contains any quantity of the following hallucinogenic substances and their salts, isomers and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only the term "isomer" includes the optical, position and geometric isomers):**
   a) **4-bromo-2, 5-dimethoxyamphetamine.**
   b) **2, 5-dimethoxyamphetamine.**
   c) **4-methoxyamphetamine.**
   d) **5-methoxy-3, 4-methylenedioxyamphetamine.**
   e) **4-methyl-2, 5-dimethoxyamphetamine.**
   f) **3, 4-methylenedioxymethamphetamine (MDMA).**
   g) **3, 4-methylenedioxy amphetamine.**
   h) **3, 4, 5-trimethoxy amphetamine.**
   i) **alpha-ethyltryptamine.**
   j) **Bufotenine.**

k) **Diethyltryptamine.**
l) **Dimethyltryptamine.**
m) **Ibogaine.**
n) **Lysergic acid diethylamide.**
o) **Cannabis, except the synthetic isomer of delta-9-tetraydrocannabinol.**
p) **Mescaline.**
q) **Parahexyl.**
r) **Peyote.**
s) **N-ethyl-3-piperidyl benzilate.**
t) **N-methyl-3-piperidyl benzilate.**
u) **N-hydroxy-3,4-methylenedioxyamphetamine.**
v) **N,N-Dimethylamphetamine.**
w) **3, 4-methylenedioxy-n-ethylamphetamine.**
x) **Psilocybin.**
y) **Psilocyn.**
z) **Ethylamine analog of phencyclidine.**
aa) **Pyrrolidine analog of phencyclidine.**
bb) **1-(1-(2-thienyl)cyclohexyl)pyrrolidine.**
cc) **Thiophene analog of phencyclidine.**
dd) **Aminorex.**
ee) **4-bromo-2,5-dimethoxyphenethylamine.**

4. **Any of the following substances having a depressant effect on the central nervous system, including their salts, isomers and salts of isomers, unless specifically excepted or listed in another schedule, whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:**
   a) **Mecloqualone.**
   b) **Methaqualone.**
5. **Gamma-hydroxybutyric acid, any salt, hydroxybutyric compound, derivative or preparation of gamma-hydroxybutyric acid, including any isomers, esters and ethers and salts of isomers, esters and ethers of gamma-hydroxybutyric acid, except gamma-butyrolactone if the existence of the isomers, esters and salts is possible within the specific chemical designation. Notwithstanding any other provision of the federal food, drug and cosmetic act, for purposes of security requirements imposed by law or regulation on registered distributors and registered manufacturers, this substance if manufactured, distributed or processed in accordance with an exemption approved under section 505 of the federal food, drug and cosmetic act is a controlled substance in schedule III pursuant to section 36-2514.**
6. **Any of the following stimulants including their salts, isomers and salts of isomers, unless specifically excepted or listed in another schedule, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:**
   a) **Methcathinone.**
   b) **Fenethylline.**
   c) **N-ethylamphetamine.**
   d) **(+)cis-4-methylaminorex((+)cis-4,5-dihydro-4-methyl-5- phenyl-2-oxazolamine).**
   e) **METHYLENEDIOXYMETHCATHINONE.**
   f) **METHYLENEDIOXYPYROVALERONE.**
   g) **METHYLMETHCATHINONE.**

B. **The board may except by rule any compound, mixture or preparation containing any substance listed in this section from the application of all or any part of this chapter if the compound, mixture or preparation contains one or more active medicinal ingredients and if**

the admixtures are included therein in combinations, quantity, proportion or concentration that vitiates the potential for abuse.

END_STATUTE

Sec. 3. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law."

Amend title to conform

and, as so amended, it do pass

REFERENCE TITLE: AHCCCS; transplants; standards

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2511

Introduced by: Representatives Heinz, Tovar

AN ACT

AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2907, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2907. Covered health and medical services; modifications; related delivery of service requirements; definition

A. **Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:**

1. **Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.**
2. **Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.**
3. **Other laboratory and x-ray services ordered by a physician or a primary care practitioner.**
4. **Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1, 2006,~~ Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through**

a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.

5. **Medical supplies, durable medical equipment and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.**
6. **For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.**
7. **Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.**
8. **Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.**
9. **Podiatry services ordered by a primary care physician or primary care practitioner.**
10. **Nonexperimental transplants approved for title XIX reimbursement. THE ADMINISTRATION MUST CONFORM ITS COVERAGE OF TRANSPLANTS FOR ELIGIBLE MEMBERS TO THE STANDARDS ADOPTED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, 42 CODE OF FEDERAL REGULATIONS PART 482.**
11. **Ambulance and nonambulance transportation, except as provided in subsection G of this section.**

B. **The limitations and exclusions for health and medical services provided under this section are as follows:**

1. ~~**Beginning on October 1, 2002,**~~ **Circumcision of newborn males is not a covered health and medical service.**
2. **For eligible persons who are at least twenty-one years of age:**
   a) **Outpatient health services do not include occupational therapy or speech therapy.**
   b) **Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand ~~five hundred~~ FIVE HUNDRED dollars per contract year.**
   c) **Insulin pumps, percussive vests and orthotics are not covered health and medical services.**
   d) **Durable medical equipment is limited to items covered by medicare.**
   e) **Podiatry services do not include services performed by a podiatrist.**

~~**(f) Nonexperimental transplants do not include the following:**~~
~~**(i) Pancreas only transplants.**~~
~~**(ii) Pancreas after kidney transplants.**~~
~~**(iii) Lung transplants.**~~
~~**(iv) Hemopoetic cell allogenic unrelated transplants.**~~
~~**(v) Heart transplants for non-ischemic cardiomyopathy.**~~
~~**(vi) Liver transplants for diagnosis of hepatitis C.**~~

~~(g)~~ **(f) Beginning October 1, 2011, bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.**

~~(h)~~ **(g) Well exams are not a covered health and medical service, except mammograms, pap smears and colonoscopies.**

C. **The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.**

D. **The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.**

E. **The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.**

F. **The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.**

G. **The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided to persons who are eligible pursuant to sections 36-2901.01 and 36-2901.04 and who reside in a county with a population of more than five hundred thousand persons. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.**

H. **The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.**

I. **If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as**

optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

J. **Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).**

K. **All health and medical services provided under this article shall be provided in the geographic service area of the member, except:**
   1. **Emergency services and specialty services provided pursuant to section 36-2908.**
   2. **That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.**

L. **Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.**

M. **The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.**

N. **For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201.**

END_STATUTE

REFERENCE TITLE: AHCCCS; covered services

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2522

Introduced by: Representative Heinz

AN ACT

AMENDING SECTIONS 36-2907 AND 36-2989, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2907, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2907. Covered health and medical services; modifications; related delivery of service requirements; definition

A. **Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:**

1. **Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.**
2. **Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.**
3. **Other laboratory and x-ray services ordered by a physician or a primary care practitioner.**
4. **Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1, 2006,~~ Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.**
5. **Medical supplies, durable medical equipment and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.**
6. **For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.**
7. **Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.**
8. **Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.**
9. **Podiatry services ordered by a primary care physician or primary care practitioner.**
10. **Nonexperimental transplants approved for title XIX reimbursement.**
11. **Ambulance and nonambulance transportation, except as provided in subsection G of this section.**
12. **HOSPICE CARE.**

B. **The limitations and exclusions for health and medical services provided under this section are as follows:**

1. **~~Beginning on October 1, 2002,~~ Circumcision of newborn males is not a covered health and medical service.**
2. **For eligible persons who are at least twenty-one years of age:**

a) **Outpatient health services do not include occupational therapy or speech therapy.**
b) **Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand ~~five hundred~~ FIVE HUNDRED dollars per contract year.**
c) **Insulin pumps, percussive vests and orthotics are not covered health and medical services.**
d) **Durable medical equipment is limited to items covered by medicare.**
e) **Podiatry services do not include services performed by a podiatrist.**

~~(f) Nonexperimental transplants do not include the following:~~
~~(i) Pancreas only transplants.~~
~~(ii) Pancreas after kidney transplants.~~
~~(iii) Lung transplants.~~
~~(iv) Hemopoetic cell allogenic unrelated transplants.~~
~~(v) Heart transplants for non-ischemic cardiomyopathy.~~
~~(vi) Liver transplants for diagnosis of hepatitis C.~~

~~(g)~~ (f) Beginning October 1, 2011, bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.
~~(h)~~ (g) Well exams are not a covered health and medical service, except mammograms, pap smears and colonoscopies.

C. **The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.**
D. **The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.**
E. **The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.**
F. **The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.**
G. **The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided to persons who are eligible pursuant to sections 36-2901.01 and 36-2901.04 and who reside in a county with a**

population of more than five hundred thousand persons. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

H. **The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.**

I. **If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.**

J. **Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).**

K. **All health and medical services provided under this article shall be provided in the geographic service area of the member, except:**

1. **Emergency services and specialty services provided pursuant to section 36-2908.**
2. **That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.**

L. **Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.**

M. **The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.**

N. **For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201.**

END_STATUTE

Sec. 2. Section 36-2989, Arizona Revised Statutes, is amended to read:

START_STATUTE36-2989. Covered health and medical services; modifications; related delivery of service requirements

A. **Except as provided in this section, ~~beginning on October 1, 2001,~~ health and medical services as ~~defined~~ PRESCRIBED in section 36-2907 are covered services and include:**

1. **Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients, that are medically necessary and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this paragraph, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized by federal law.**
2. **Outpatient health services that are medically necessary and ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. For the purposes of this paragraph, "outpatient health services" includes services provided by or under the direction of a physician or a primary care practitioner.**
3. **Other laboratory and x-ray services ordered by a physician or a primary care practitioner.**
4. **Medications that are medically necessary and ordered on prescription by a physician, a primary care practitioner or a dentist licensed pursuant to title 32, chapter 11.**
5. **Medical supplies, equipment and prosthetic devices.**
6. **Treatment of medical conditions of the eye, including eye examinations for prescriptive lenses and the provision of prescriptive lenses for members.**
7. **Medically necessary dental services.**
8. **Well child services, immunizations and prevention services.**
9. **Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this article. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with a contractor who elects not to provide family planning services.**
10. **Podiatry services that are performed by a podiatrist licensed pursuant to title 32, chapter 7 and that are ordered by a primary care physician or primary care practitioner.**
11. **Medically necessary pancreas, heart, liver, kidney, cornea, lung and heart-lung transplants and autologous and allogeneic bone marrow transplants and immunosuppressant medications for these transplants ordered on prescription by a physician licensed pursuant to title 32, chapter 13 or 17.**
12. **Medically necessary emergency and nonemergency transportation.**
13. **Inpatient and outpatient behavioral health services that are the same as the least restrictive health benefits coverage plan for behavioral health services that are offered through a health care services organization for state employees under section 38-651.**
14. **HOSPICE CARE.**

B. **The administration shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section.**

C. **To the extent possible and practicable, the administration and contractors shall provide for the prior approval of medically necessary services provided pursuant to this article.**

D. **The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article.**

E. **Behavioral health services shall be provided to members through the administration's intergovernmental agreement with the division of behavioral health in the department of health services. The division of behavioral health in the department of health services shall use its established diagnostic and evaluation program for referrals of children who are not already enrolled pursuant to this article and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section**

36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.

F. **The director shall adopt rules for the provision of transportation services for members. Prior authorization is not required for medically necessary ambulance transportation services rendered to members initiated by dialing telephone number 911 or other designated emergency response systems.**

G. **The director may adopt rules to allow the administration to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this article without documentation as to need by at least two physicians or primary care practitioners.**

H. **All health and medical services provided under this article shall be provided in the geographic service area of the member, except:**
   1. **Emergency services and specialty services.**
   2. **The director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if it is determined that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding section 36-2981, paragraph 8 or 11, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state that are similar to title 32, chapter 13, 15, 17 or 25.**

I. **Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes of making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.**

J. **The director shall adopt rules that prescribe the coordination of medical care for members and that include a mechanism to transfer members and medical records and initiate medical care.**

K. **The director shall adopt rules for the reimbursement of specialty services provided to the member if authorized by the member's primary care physician or primary care practitioner.**

END_STATUTE

Sec. 3. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

HOUSE OF REPRESENTATIVES
HB 2706
education; Arizona empowerment accounts
Sponsors: Representatives Lesko, Court, Gowan

X	Committee on Ways and Means
	Caucus and COW
	House Engrossed

OVERVIEW

HB 2706 establishes Arizona Empowerment Accounts for qualified students, consisting of 90 percent of the State Aid that would otherwise have been computed for the student.

History

Equalization assistance for education (State Aid) is computed by determining the difference between a school district's budget capacity for that fiscal year and the amount of revenue raised by the district through their local property tax levy (A.R.S. § 15-971).

PROVISIONS

- Establishes Arizona Empowerment Accounts (Account) for the stated purpose of providing educational options for Arizona students.
- Defines *qualified school* to mean a nongovernmental primary or secondary school or a preschool for handicapped students.
- Defines *qualified student* to mean a child who is eligible to receive disability related services from a school district or who has been identified as disabled either by the school district or under federal guidelines.
- Defines *department, eligible post secondary institution,* and *parent*.
- Allows the parent of a qualified students to enroll for an Account by signing an agreement to do the following:
  - Provide an education in at least the subjects of reading, grammar, mathematics, social studies and science.
  - Not enroll the qualified student in a school district or charter school and release the school district from all obligations to educate the qualified student.
  - Not accept a scholarship from a School Tuition Organization.
- Specifies that a signed agreement constitutes required school attendance.
- Stipulates that the use of monies deposited in the Account are limited to the following expenses:
  - Tuition or fees and required textbook costs at a qualified school.
  - Educational therapies or services from a licensed or accredited practitioner or provider.
  - Tutoring services.
  - Curriculum.
  - Tuition or fees for a nonpublic online learning program.
  - Fees for standardized testing and advanced placement or any other exams related to college or university admission.
  - Contributions to a federally qualified tuition program.
  - Tuition or fees and required textbook costs at an eligible postsecondary institution.
  - Account management fees.
- Requires the state to deposit 90 percent of the state aid that would otherwise be computed for the qualified student into that student's Account.
  - States that transfers will be made quarterly.
- Requires that parents annually renew the qualified student's Account.
- Prohibits qualified schools or service providers purchased with Account monies from sharing, refunding or rebating any Account monies with the parent or qualified child.
- Requires the Arizona Department of Revenue (DOR) to contract with, and supervise private financial management firms to manage the Accounts.
- Requires DOR to conduct, or contract for random annual Account audits to ensure compliance.
- Allows DOR to remove any parent or qualified student's eligibility for an Account for the misuse of Account monies, and to refer such cases to the Attorney General for investigation.
  - Permits parents to appeal DOR's decision.
- Allows DOR to deduct up to 3 percent of the amount of student state aid from each Account for administrative costs.
- Allows DOR to adopt rules for the administration of Accounts.
- Prohibits government agencies from exercising control or supervision over any nonpublic school or home school.

- Specifies that any qualified school that accepts an Account derived payment from a parent is not an agent of the state or federal government.
- States that qualified schools are not required to alter their creed, practices, admissions policies or curriculum in order to accept students that pay tuition or fees with Account monies.
- Stipulates that in any legal proceeding challenging the measure's application, the state bears the legal burden of establishing the necessity of the law and that it does not impose any undue burden on qualified schools.